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ABSTRACT

This binder includes 102 reproducible articles written specifically for the parents of children, ages 3 and younger, who have been diagnosed with physical disabilities and delays. Practitioners are encouraged to select appropriate articles and: distribute them at parent-clinician conferences; send them home with any parent communication, report cards, and homework; provide them in a waiting area; and distribute them at workshops, inservices, and during consultation. Articles are grouped into sections on: motor development (11), therapeutic movement activities (9), therapeutic equipment (7), communication (8), vision (5), hearing (7), cognitive development and play (9), personal care (6), feeding (6), emotional development (10), social development (8), and family support (16). References are listed at the end of some articles. (PB)

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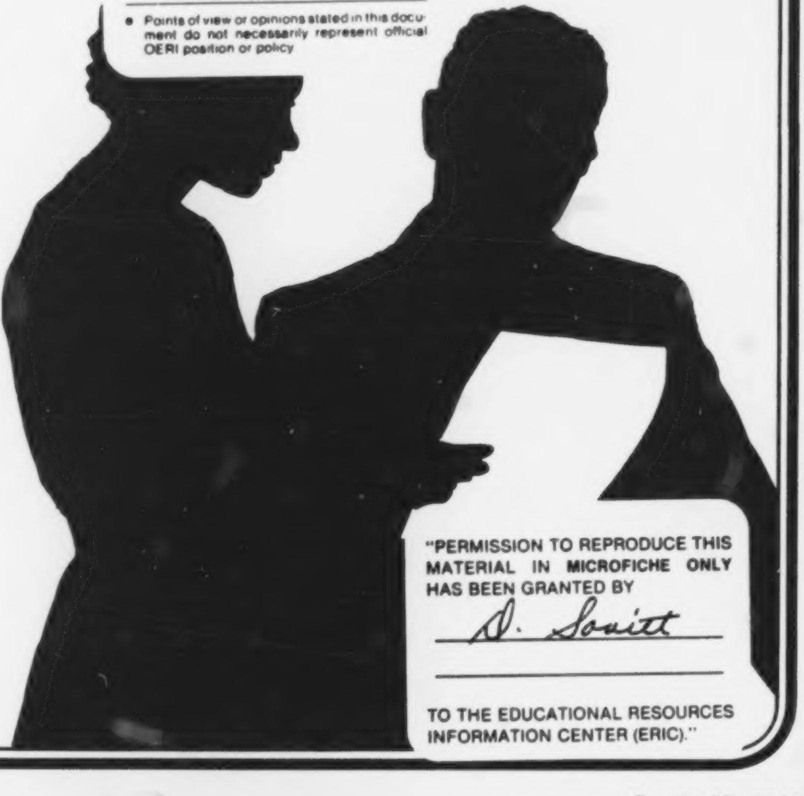
PARENT ARTICLES
for Early Intervention

Edited by Marsha Dunn Klein, M.Ed., O.T.R.

Illustrations drawn under contract by Corwyn Zimbleman



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Parent Articles for Early Intervention

Edited by
Marsha Dunn Klein, M.Ed., O.T.R.

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Author Index

Belk-Kanouse, Judith, Ph.D., CCC-SLP, CCC-A. . . . Communication 7
Benjamin, Kay, O.T.R. . . . Personal Care 1
Bennetti, Robert J., M.Ed. . . . Social 8
Bierman, Judith C., P.T. . . . Motor 2

Caldwell, Linda E., P.T. . . . Motor 5, 11
Clauss, Barbara E., M.Ed., P.T. . . . Equipment 2, 3, 4
Cohen, Michael, M.D. . . . Emotional 4, 5
Cupps, Barbara, P.T. . . . Motor 7

DeVerna, Kathleen Walden . . . Cognitive/Play 3, 6; Family 2, 8
Dunaway, Avtar, O.T.R. . . . Cognitive/Play 8; Personal Care 6
Dunlap, Margaret R., Ph.D. . . . Emotional 1, 6; Social 1

Elwinger, Elyda S., Ed.D., O.T.R., CCC-Sp. . . . Cognitive/Play 5; Social 4, Family 13

Faux, Cassandra, M.S., CCC-SLP . . . Communication 5

Galilee, Miriam . . . Movement 1
Ganz, Jeanne Sangirardi, O.T.R. . . . Motor 9
Garis, Karla, B.S. . . . Family 6, 9
Gettings, Joan Peet, O.T.R. . . . Personal Care 4, 5
Goldman, Ellen, M.S., CCC-A. . . . Hearing 1, 2, 3

Heald, Melinda M., M.S., CCC-A. . . . Hearing 4
Heerboth, Jill, M.S., CCC . . . Communication 2
Hendrickson-Pfeil, Sharon, M.S., M.A., CCC . . . Communication 3; Emotional 8; Social 6, 7
Herziger, Helen, M.S.W. . . . Family 16
Hypes, Barbara, P.T. . . . Motor 6, Movement 5

Jorgensen, Peggy, R.N. . . . Family 14

Kant, Esther, O.T.R. . . . Personal Care 3
Kiser, Joni M., M.Ed. . . . Hearing 5
Klein, Marsha Dunn, M.Ed., O.T.R. . . . Vision 3; Feeding 6
Kliebhan, Linda A., P.T. . . . Motor 8
Koutz, Jeanne, O.T.R. . . . Feeding 2

Larson, Caroline, O.T.R. . . . Movement 9
Levine, Linda M., M.Ed. . . . Cognitive/Play 1, 2; Social 3, 5

Maldonado, Jeannie M., M.S.Ed. . . . Cognitive/Play 9
Marts, Kelly . . . Vision 5
Medvescek, Chris, B.A. . . . Family 10, 12
Morris, Suzanne Evans, Ph.D., CCC-Sp. . . . Communication 6; Feeding 5

Nardella, Maria T., M.A., R.D. . . . Feeding 1
Nelson, Geri, M.Ed. . . . Hearing 6, 7
Newmark, Sanford, M.D. . . . Feeding 4
Norgard, Kathryn, Ph.D. . . . Family 1, 7

O'Connell, Mary, P.T. . . . Movement 2, 3, 4
Overbeck, Daniel B., Ph.D. . . . Emotional 2, 7, 9, 10; Social 2

Peddy, Linki D. . . . Emotional 3
Prosnitz, Elaine, M.S. . . . Family 11, 15

Sampliner, Linda H., Ed.D. . . . Family 5
Stebbins, V. Fay, R.N. . . . Equipment 6, 7

Tharp, Linda, R.N. . . . Family 14
Topor, Irene, M.Ed. . . . Vision 1, 2
Tracy, Barbara, P.T. . . . Movement 6; Equipment 5; Personal Care 2
Trimble, Shelley, P.T. . . . Movement 7, 8

Vestal, Judith C., M.A., O.T.R. . . . Cognitive/Play 4, 7; Feeding 3; Family 3, 4

Wallace, Timmie, P.T. . . . Motor 4; Equipment 1
Wallis, Allison, P.T. . . . Motor 1, 3
Williams, Nancy, M.Sc., CCC-Sp. . . . Communication 1, 4; Vision 4
Witt, Beth, M.A. . . . Motor 10

Yeatts, Rebecca D., M.S., CCC-Sp. . . . Communication 8

Contents

Introduction ix

How to Use This Book ix

Motor Development

1: Principles of Normal Development .1
2: Components of Motor Development 3
3: Development of Head and Trunk Control 5
4: The Developmental Sequence for Rolling 9
5: The Development of Righting and Equilibrium Reactions 11
6: Considerations for Normal Sitting 13
7: The Developmental Sequence for Standing and Walking 17
8: Normal Foot Development 19
9: Fine Motor Development: The First Year 21
10: Perceptual-Motor Development in the Toddler 23
11: Variations in Muscle Tone 25

Therapeutic Movement Activities

1: Infant Massage: The Loving Touch 27
2: Lifting and Carrying Your Child 29
3: Making Range-of-Motion Exercises Part of Your Child's Day 31
4: Incorporating Movement Activities into Your Child's Day 33
5: The Ball as a Tool for Home Therapy 35
6: Daily Activities for the Child with Low Tone 37
7: Daily Activities for the Child with High Tone 39
8: Daily Activities for the Child with Hemiplegia 41
9: Water Fun and Swimming 43

Therapeutic Equipment

1: Choosing a Wheelchair 45
2: Homemade Equipment for Lying 47
3: Homemade Equipment for Sitting 49
4: Homemade Equipment for Standing and Mobility 51
5: Mobility Aids 55
6: Your Child's Gastrostomy Tube 57
7: Your Child's Tracheostomy 59

Communication

1: Normal Development of Receptive Language 61
2: Normal Development of Language Precursors 63
3: Expressive Language Development 65
4: Normal Development of Respiration for Speech 67

5: Communication Options for the Physically Disabled Child 69
6: Effects of Feeding on Speech Development 71
7: Encouraging Listening Skills 73
8: The Development of Imitation Skills 75

Vision

1: Normal Visual Development 77
2: Testing Your Child's Vision 79
3: Encouraging Movement in the Visually Impaired Infant 81
4: Encouraging Language Development in the Visually Impaired Child . . 83
5: Toys and Experiences for Your Visually Impaired Child 85

Hearing

1: Normal Auditory Development 87
2: Hearing and Hearing Loss 89
3: Your Child's Hearing Aid 91
4: Childhood Ear Infections 93
5: Teaching Language to Your Hearing-Impaired Child 95
6: Communicating with the Hearing-Impaired Child: The Aural-Oral Approach 97
7: Total Communication with the Hearing-Impaired Child 99

Cognitive Development and Play

1: Child's Play: From Birth to Age 3 101
2: Development of Intelligence in Children: The First Three Years 103
3: Problem Solving 105
4: Sensory Exploratory Play 107
5: Planning an Optimal Environment 109
6: Music and the Young Child 111
7: Encouraging Your Child's Play 113
8: Making and Adapting Toys for the Child with Disabilities 115
9: How to Choose and Adapt a Toy for Your Child 119

Personal Care

1: Development of Dressing Skills 121
2: Dressing the Child with Low Tone 123
3: Dressing the Child with High Tone 125
4: Dressing the Child with Hemiplegia 127
5: Your Child's Personal Hygiene 131
6: Toilet Training 135

Feeding

1: Choosing the Right Formula 139
2: Introducing Your Baby to Solid Food 141
3: Self-Feeding Readiness 143

4: Failure to Thrive 145
5: Switching from Tube Feeding to Oral Feeding 147
6: Your Child Has a Cleft Lip or Palate 149

Emotional Development

1: Normal Emotional Development 151
2: Emotional Development of Children with Disabilities 153
3: Being Aware of Your Child's Needs 155
4: Preventing Sleep Problems 157
5: Crying: What Does It Mean? 159
6: Anger in Children 161
7: Anxiety, Frustration, and Your Child's Behavior 163
8: Problem Behaviors: What Do They Mean? 165
9: Stereotypic Behaviors 167
10: Self-Injurious Behavior 169

Social Development

1: Normal Development of Social Skills 171
2: Self-Control in Infants and Young Children 173
3: Developing Responsibility 175
4: Teaching Independence: Growing Up and Away 177
5: Encouraging Cooperation in Young Children 179
6: Encouragement 181
7: Natural and Logical Consequences 183
8: Changing Your Child's Behavior: The Behavioral Approach 185

Family Support

1: Families with Children with Disabilities 187
2: Having Another Child 189
3: Grandparents 191
4: Brothers and Sisters 193
5: Good Grieving 195
6: De-stress Your Life 197
7: Giving and Getting Support 199
8: Taking Care of Yourself 201
9: Humor for the Health of It 203
10: Going Out! 205
11: Dealing with Your Child's Difference 207
12: Being Partners with Your Child's Service Providers 209
13: Parents as Advocates for Children 211
14: Organizing Your Child's Care 213
15: Planning Transitions for Your Child 217
16: Understanding the IFSP 219

Introduction

Parent Articles for Early Intervention comprises 102 reproducible articles written especially for the parents of children, ages birth through 3, who have been diagnosed with a variety of physical disabilities and delays.

Informed and actively involved parents can be crucial members of the child's team of caregivers, since the therapy you provide is most effective when it is done at home as well as during office visits. Often, though, the parents are not prepared to deal with their child's needs, or with the host of professionals with whom they are suddenly involved.

Parent Articles for Early Intervention provides a wealth of easy-to-understand information about specific conditions and about the general skills *every* parent needs. A group of practicing clinicians suggested the topics to be covered; the articles were written by professionals familiar with the special needs of children with disabilities—and with the special needs of the parents of those children. The articles are designed to help parents understand the therapeutic process, the development of physical and communication skills, and the ways they can help their child develop to full potential.

How to Use This Book

The articles are grouped under twelve major headings—use the table of contents to find appropriate articles.

Having determined that a particular article is suitable for the parents of a client, duplicate the article and give it to the parents. In most cases, it is best to give one article at a time. Some parents may not want any written information, while others may actively request more information. Be sensitive to the reactions of the parents when deciding which and how many articles to give.

The articles are useful supports for direct therapy or for consultation and may be distributed to parents in a number of settings. They may be:

- Distributed at parent-clinician conferences
- Sent home with any parent communication
- Sent home with report cards
- Sent home with homework
- Provided as a selection in the waiting room
- Distributed at workshops
- Distributed at inservices
- Distributed during consultation.

Should the parents want more information, useful reference materials are listed at the end of many articles.

MOTOR DEVELOPMENT

1: Principles of Normal Development

2: Components of Motor Development

3: Development of Head and Trunk Control

4: The Developmental Sequence for Rolling

5: The Development of Righting and Equilibrium Reactions

6: Considerations for Normal Sitting

7: The Developmental Sequence for Standing and Walking

8: Normal Foot Development

9: Fine Motor Development: The First Year

10: Perceptual-Motor Development in the Toddler

11: Variations in Muscle Tone

Principles of Normal Development

by Allison Wallis, P.T.

The word "normal" can be misleading—every person has a unique combination of strong and weak skills. The athlete may have excellent coordination but poor speech and language skills, while the chess player may have strong thinking skills but be unable to catch a ball. But they are both "normally" developed.

Still, babies develop in similar ways. Here are some of the general principles and theories of infant development.

Head to Toe

Babies develop movement or motor skills in a head-to-toe direction. They are born curled into the fetal position and immediately begin trying to lift their heads to look around. The first movements your baby can control are those of the head and eyes. Next, your baby develops the ability to bring the hands together while in a backlying position.

Your baby has active control of the mid- to lower trunk when rolling. Lower-trunk control develops when your baby brings the feet to the mouth when lying face up. Pelvic (hip) stability can be seen when your baby learns to sit alone. Hip and knee control are achieved when your baby crawls. Overall head-to-toe control appears when the baby takes the first steps, even though it takes three years for the child to develop complete control in standing postures.

Proximal to Distal

Proximal means *close to the body. Distal* means *away from the body.* The shoulder is proximal; the hand is distal. Babies must develop proximal stability before doing intricate hand and foot movements. Trunk control is needed for balance, to serve as the base of support—before working on fine hand skills, your baby must be able to sit well.

Gross-Fine-Finest

During the first year, your baby rapidly develops *gross* control of large motions. Your baby changes from a newborn without head control to a child learning to walk. This intricate and systematic process leads to head and then trunk control, shoulder stability, pelvic stability, hip control, knee control, and finally ankle and foot reactions.

From age 1 to 2, your child's focus changes to the *fine* skills—those that involve manual dexterity and problem solving. Your child sits for long periods working with blocks, puzzles, and clothing, learns to eat without help, and loves to explore.

From age 2 to 3, skills are refined even more. Your child learns to speak in sentences, uses eating utensils, learns the skills necessary for writing, and begins to understand learning concepts.

These *finest* skills must be built on a solid foundation of gross skills. Your child needs proximal/trunk control before reaching out to explore with refined hand, finger, and eye movements. For example, a child with poor trunk balance won't be able to sit well at a desk, so schoolwork may suffer.

A team of specialists can help if your child's development is delayed. The *physical therapist* deals with gross motor skills. The *occupational therapist* works with fine and finest visual and eye-hand skills. The *speech-language pathologist* works with fine to finest speech, language, and oral motor skills.

Symmetry vs. Asymmetry

Symmetry means *equal. Asymmetry* means *unequal,* as when one side of the body works better than the other. Infants are born in an asymmetrical position because of early primitive reflexes and the lack of muscle power and control. By about age 4 months, the infant begins to show symmetry in supported positions.

Soon, your baby begins controlling asymmetrical movements. Kicking while lying face up comes first. At first, both legs kick in a random reflex. Then your baby learns to draw both legs toward the tummy while reaching for the thighs.

Next is hands to knees, hands to feet, and finally feet to mouth. At the same time, your baby learns to kick alternate legs, enjoying the movement and the sounds of feet banging onto the floor.

Reflexive, Automatic, Voluntary Movement

The newborn's central nervous system is immature, so your baby's movements are jerky and random. At first, if one leg bends the other bends with it. If one hand is fisted, the other will also be fisted.

These early movements are *reflexes*—preprogrammed responses to outside influences. For about the first four months, many reflexes help protect the infant. If the feet are touched, they recoil towards the body. If the cheek is stroked, your baby turns in hope of finding food.

Automatic reactions appear at about 4 months. These help your baby stay balanced and vertical. Automatic reactions also move the limbs away from the body to protect the face in a fall.

Voluntary movements—those done deliberately—are at the highest level of control. Think of the infant who has just learned to sit. The baby sees a toy but doesn't have the coordination to move out of the sitting position. Soon, though, the child can decide to get the toy, get onto hands and knees, crawl to the toy, resume sitting, and play. What control!

Stability vs. Mobility

Newborns can't move or control their bodies very well. Muscular length and joint mobility increases as the infant begins to stretch and use the muscles.

Working the back muscles helps your baby work out of the fetal position. The muscles on the front of the body lengthen as your child pushes up from a tummylying position. The muscles on the back of the body and legs lengthen when your baby's feet are brought to the mouth in the backlying position.

Once your baby has some mobility, the next job is to gain stability by learning to balance the muscles on the front and back of the body. A stable position supplies a base from which to move and a place to return to—a home base—after moving or losing balance.

Active mobility is the next goal. With a stable trunk and pelvis, your baby can reach out without losing balance.

Weight bearing precedes movement into space

Your baby will put weight on the arms and legs to prepare the limbs for more advanced movements. From a tummylying position, your baby first pushes up onto both arms and hands, and then learns to shift weight from front to back and then side to side. The shoulders grow stronger and more stable; soon, your baby can prop up on one arm while reaching out with the other.

Two steps forward, one step back

Development seems like a staircase. But it's really more like a rope, since the many skills and movements are intertwined. That's why you need to understand your child's earlier development and potential for future development.

Your baby can't concentrate on all areas of development at the same time. Instead, the baby will concentrate on one area and appear to lose skills in another. Children often stop talking for a few weeks when they first learn to walk.

Your baby might also return to more primitive patterns of movement when a skill becomes difficult or if the baby's balance is challenged. When first learning to sit, your baby's arms will be held out at the sides and the shoulders will be elevated for greater stability. But when your baby is on the floor lying face up, the shoulders are relaxed and the arms reach forward into space with control.

Summary

Normal development is never "normal." A unique set of genetic and environmental forces guides each child's development. Plus, each child has a unique personality and way of learning.

Try not to compare your child with other children—development means growing, not racing. It's much better to compare your "yesterday" child with your "today" child, and see the changes your child has accomplished. We're *all* "normal," and we're all unique!

Components of Motor Development

by Judith C. Bierman, P. T.

It's easy to take the developmental process for granted; most of us never think about how complicated growing up is. Newborns depend on their parents for everything; the goal of normal motor development is for these babies to become healthy, independent adults. That means the person can function well in each of these areas:

Gross motor—The ability to hold the body up against gravity and to move between positions.

Fine motor—The ability to use the hands.

Self-help—The ability to take care of oneself. This includes feeding, dressing, hair care, bathing, and cooking.

Oral-motor—The ability to control the tongue, lips, and cheeks to talk and to bite, chew, and swallow food.

How can my child's development be tested?

Here are two of many ways your child's development can be tested:

Developmental testing. One way to study development is to list all the activities that babies or children do in the order that they learn to do them. These lists are called "developmental scales" and can be used to test any baby. Your baby is given many different tasks, and a developmental age is assigned by comparing your baby's skills with those of other children. The developmental age is the age when most babies can do all the tasks completed by the baby who was tested.

Children develop motor skills at different rates. Culture, the abilities of family members, and even your child's personality all influence how fast your child develops.

Reflex testing. Reflexes are movement patterns that always occur after the child is touched or moved in a specific way. For example, your child's doctor may hold your child in the air like an airplane, with a hand under the tummy. This is to see if the Landau reflex is present. If it is, your baby will lift the head and feet up in the air. If the reflex is absent, the head and legs will drop below the doctor's hand. This reflex should appear by the time your child is 6 months old.

Reflex testing helps determine how mature your child's nervous system is. A reflex that appears too early or stays too long can show problems in the brain's development.

What do the tests determine?

Developmental and reflex testing tell us if a child is developing at the same speed and order that normal children develop. But the tests cannot tell *why* your child develops in a certain way. Why can a 6-month-old sit and a 3-month-old not sit? Why can't babies talk until they are about a year old? The answers to these kinds of questions lie in understanding how children gain control and coordination of their own bodies.

What are the components of movement?

Here are the different things your child must control and coordinate in order to perform a motor skill or show a reflex:

Range of motion. Each body joint has a typical arc it should move through, stretching the muscles as it goes. Your child's ability to do things will be decreased if a stiff joint keeps a body part from moving. For example, your child won't be able to sit up straight if the hips won't bend enough. A normal newborn has many limitations because of tight muscles, which must be stretched out as the baby develops. A newborn's hamstring muscles (on the back of the upper legs) are tight, but the muscles stretch as the child puts feet to mouth. By 10 months the baby can sit independently, with legs straight forward.

Sensation/perception. The ability to move is closely tied to our sensory systems. If an adult loses the feeling in a body part, the person usually stops using that part.

Children born with a sensory problem may be able to adapt, but they will not function the same as someone without the problem. Normal babies can see, hear, taste, and feel at birth, but they show definite improvement or refinement in these areas as they develop. For example, a young child may not be able to hold a small object and say what it is without looking at it. An older child develops this perceptual ability.

Strength. Muscle strength is the ability of the muscles to do work. Babies cannot even hold the weight of their limbs up against gravity. By doing exercises many times, the muscles gain strength so that the child can lift heavier and heavier objects.

Respiration. All normal babies are able to breathe at birth. The size of each breath, the rate of breathing, and the manner of breathing change, especially in the first year. At first, your baby uses the diaphragm (the flat muscle under the ribs) to take shallow, quick, irregular breaths. By the end of the first year, many other muscles assist the diaphragm, and your child takes deeper, slower breaths. This greater respiratory base allows the baby to do more activities for longer periods of time and to control breathing for speech.

Neuromotor control. To function normally, a person must be able to control the stiffness—the muscle tone—in the limbs and trunk. Sometimes, stiff muscles in the arms, legs, and body are necessary. At other times, they need to be limber. You need to stiffen your body more to walk a tightrope than to walk a line painted on the floor. At first, your baby lacks this stiffness control. Control comes to the upper body in the first four months. Later, the lower body gains control.

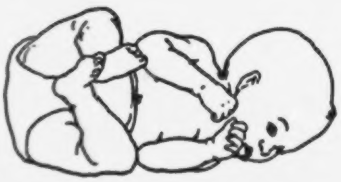
Your child must also be able to balance the muscles so the joints can bend or straighten, move to either side, and rotate. A young baby can just lift the head; as the muscles in the lower back gain control, the child is able to rise onto the elbows. Later, the child is able to stand alone, to shift weight to one leg to take a step, and, finally, to twist the body. Now the child can learn to skip or throw a ball.

Motor development happens at different rates in different children, and children can change easily. The way you play with and handle your child can influence how your child develops. Your doctor or therapist can tell you how to help your child reach certain milestones more easily.

Development of Head and Trunk Control

by Allison Wallis, P. T.

Because room in the womb is so limited, babies are born curled into the fetal position.



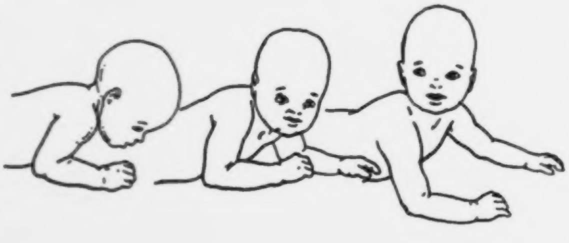
After birth, the fetal position helps protect the baby. The strong curving—called *flexion*—lasts for about sixteen days, and makes it seem as if the baby has some head control, since the head appears to be held in the middle. The flexion makes it uncomfortable for the baby to stay in the tummylying position, because it drives the baby's weight onto the face.

Development of extension

Your baby automatically begins to move out of the fetal position. *Extension* is your baby's first active movement; it occurs when the skull, neck, and back work against gravity when the baby is tummylying. At first, the head is turned to the side and the arms are beneath the body when attempting the first head lift.

Reflexes called *righting reactions* help your baby keep the head upright and aligned with the body. Righting reactions, which are stimulated in the inner ear by the force of the surface pushing against the head, forces within the vertebra, and the infant's visual interest, keep the head in a position where the eyes are horizontal and the face is vertical.

At first, all your baby can do is lift the head briefly and turn it from side to side. After lots of practice and repetition, the baby can hold the head at an angle with the forearms carrying some weight. Finally, the head comes all the way up and the elbows are straight.

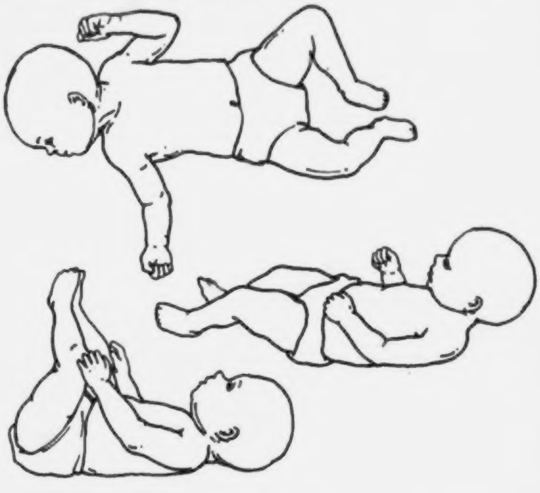


Development of flexion

Extension appears first, but *flexion* follows soon after. Flexion develops with the baby in the backlying position. Flexion occurs when the muscles on the front of the body contract. Once your baby works out of the fetal position, active flexion begins.

Your baby's posture is not symmetrical because of something called the asymmetrical tonic neck reflex—the ATNR. This reflex affects the posture of the head, neck, and limbs. Your baby begins to work out of the ATNR by exploring the chest with the hands. As the hands move toward each other, the head and eyes begin to move toward the middle briefly.

After lots of practice and repetition, your baby can put one hand over the other on the chest or abdomen. Your baby examines the hands carefully—vision helps the head remain stable in the middle, giving your baby a symmetrical position. Then the baby begins to lift the head, as if doing sit-ups. With the hands at the center of the body and the eyes looking down to the feet, the baby begins to lift the legs toward the body. The hands first reach the thighs, then the knees, then the feet. Finally, the baby is able to put the feet in the mouth.



Development of lateral movement

Your baby achieves symmetry—the midline position—when extension and flexion in the head and trunk are balanced. This lets the baby learn about the middle of the body. The baby is able to push up, bring feet to mouth, and sit momentarily. Now it's time to move out of these positions.

Controlled flexion and extension work together to bring about lateral movements. In lateral movements, all the body weight shifts to one side, freeing the opposite side for movement. In the tummylying position, the baby begins to roll, pivots in a circle on the tummy, and crawls on the tummy. In the backlying position, your baby begins to roll.

When sitting, your baby can prop on the arms to keep from falling and can reach for toys placed to the side or held in the air. Lateral movements are how the baby learns about the sides of the body.

Development of rotation

Rotation—a twisting movement along the spine—is the most advanced movement pattern. Like lateral movement, it requires a balance between flexion and extension of the head and trunk. Rotation improves the baby's balance and makes the baby's movements as efficient as possible.

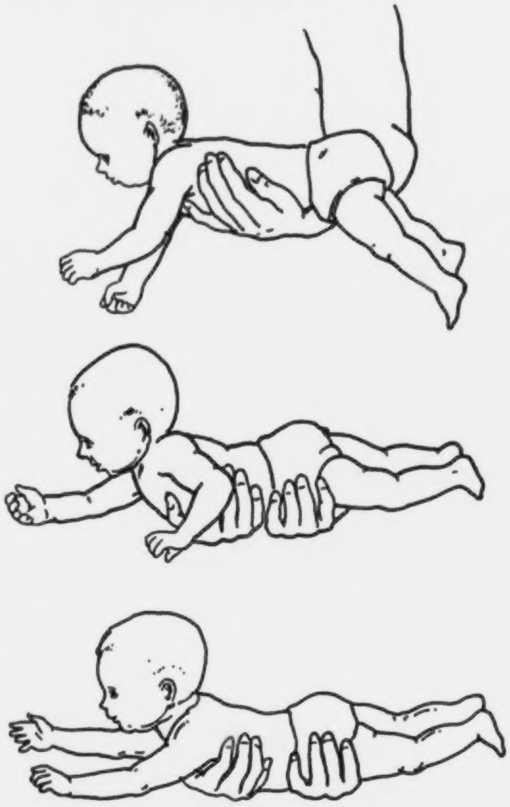
Rotation lets the baby use reflexes called *equilibrium reactions.* Equilibrium reactions are how the body responds to a shift in the center of gravity and tries to keep from falling. Rotation can be seen when your baby begins to crawl rapidly, bottom swinging from side to side.

In the sitting position, rotation can be seen when your baby turns the upper body without moving the hips. Another time is when the baby moves from sitting to hands and knees and then back to sitting. You can also see rotation in a baby's walk, when the arms swing opposite the hips. Rotation lets the baby learn about the front and back of the body and how the sides of the body work together.

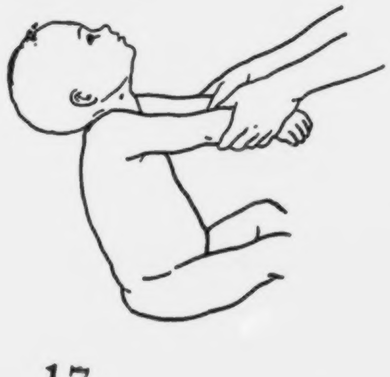
Testing head and trunk control

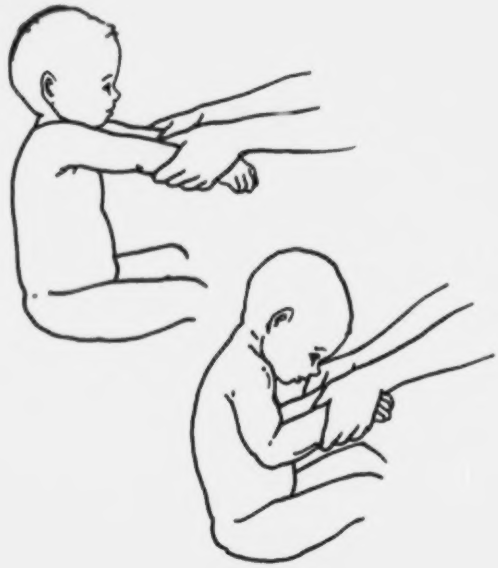
To test for head and trunk control, the examiner will put your baby into different positions to see how your baby responds to movements in space. Here are some of the things the examiner will look for.

To test extension: One way to test extension is to look for the Landau response. The examiner supports the baby under the stomach and holds the baby out in space, face down. The examiner looks to see if the baby lifts the upper body, the upper and lower body, or the entire body—looking like an airplane.

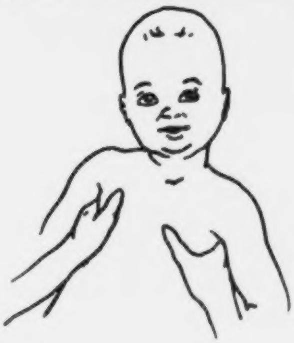


To test flexion: The pull-to-sit maneuver is used. The examiner holds the baby's arms and pulls slightly to start an upward movement, in order to see how well the baby controls the head and uses the arms.

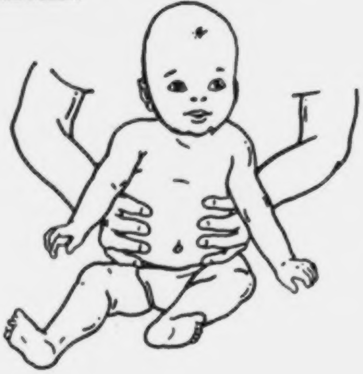




To test lateral control: This tests the optical righting reaction and the lateral trunk righting reaction. The baby is held upright and then is moved to one side. The purpose is to see how well the baby can realign the head to the body.



To test trunk righting: The baby is sitting. The examiner holds the baby at the hips and moves the baby to one side, watching to see if one side of the body lengthens while the other side shortens.



To test equilibrium: The baby sits on the examiner's lap or on a tilt table or rocker board. The body weight is shifted to one side. The first reaction will be lateral righting, followed by trunk rotation with the shoulders moving opposite the hips.

The Developmental Sequence for Rolling

by Timmie Wallace, P. T.

Rolling is often your baby's first form of independent movement. At first, your baby doesn't know about rolling. The first roll, or turnover, happens by accident. But soon, your baby learns that by moving in a certain way, something happens that makes it easier to see, feel, or reach new things.

With practice, your baby develops controlled coordination and is able to roll on purpose. The result is an early form of locomotion—now your baby has the ability to move from one location to another. Locomotion is a very important activity, and it quickly makes your baby want to explore and learn more about the world.

Rolling front to back

Before rolling from a tummylying position, your baby must be able to lift the head and turn it from side to side. Your baby also needs the strength to lift the head and upper back while beginning to push up onto the forearms.

First, the baby begins to shift weight onto one forearm while reaching out with the other hand. At the same time, the baby turns the head from side to side. This develops the back muscles, which help to lift the baby higher off the surface. At this point, your baby may roll over accidentally.

Next, the baby learns to push up with one arm, turn the head toward the pushing arm, tuck the other arm under, and turn the upper body over. The neck muscles slow the roll so that the head does not hit hard. At first, the lower body just falls over, so that the body is in proper alignment. As strength and control of head, shoulder girdle, trunk, and hips increase, the roll becomes more intentional, smooth, and coordinated.

Now the baby begins to use arm, trunk, and leg muscles to control the speed of the turnover. Your baby's world is full of interesting things; by reaching out and turning over to play, your baby practices and perfects this tummy-to-back roll.

Rolling back to front

Your baby must be able to turn the head fully from side to side. The muscles in the neck and upper body become stronger as your baby spends time playing with knees and feet in a backlying position. Your baby does not need to be strong enough to lift just the head off the floor before rolling from back to front, but, to begin the roll, your baby must have enough muscular control to lift and turn the neck and upper body.

Before rolling, the baby must be able to bring the hands to the center of the body. Reaching out and to the side is very important because your baby needs to practice moving and controlling the body as weight shifts from side to side. To begin the roll, the baby needs to be able just to reach across the body—not twist the whole upper body. While reaching across the body, the baby lifts and turns the head to begin the roll. The first rolls will be to a sidelying position.

Before rolling completely over, your baby must be able to straighten the hips. Some babies push off with their legs to begin and complete the roll.

Soon your baby will use rolling to get around the room. To do that, the baby needs control of the head and trunk and must be able to reach forward with the arms or push off with the legs. At the same time, your baby will be practicing many other activities which will increase control, strength, and speed of rolling.

Does rolling help other areas of development?

Yes. A few of these are:

- Controlled horizontal movements against gravity
- Learning to use the lower body to control the upper body
- Hearing stimulation
- Visual and optical stimulation

- Orientation away from and back to midline in horizontal planes
- Strength and flexibility throughout the spine, arms, and legs
- Feeling deep pressure throughout the trunk, which helps the baby learn about the "center of control"
- Learning to move faster and slower in a controlled way, and finding the most efficient ways to use the muscles for locomotion.

Summary

Rolling helps your baby learn about balance and tells the baby about its center of gravity and how to use it. Rolling develops strength and control and helps babies learn about how their bodies move in space and how the different parts of the body work together. And at the same time, your baby is exploring and learning about a world that gets bigger with every roll.

The Development of Righting and Equilibrium Reactions

by Linda E. Caldwell, P.T.

Gravity is a natural force which attracts physical objects to other physical objects. We experience gravity as weight, as the earth's gravity pulls things downward.

Sir Isaac Newton first described gravity. Legend says that Newton was lying under an apple tree when a falling apple hit him on the head. Newton awoke, reached up to his head, considered the damage, got up, and walked away. The apple was still lying motionless on the ground, held there by gravity. How was it that he could counteract the force of gravity and the apple could not?

Everyone, Newton included, has a natural ability to move within the force of gravity. It allows us to use coordinated, voluntary, purposeful movements to live, work, and move around. Two reactions—the *righting reaction* and the *equilibrium reaction*—control the way we move and the way we react to being moved. The reactions determine the way we hold our heads and how we stand, sit, and otherwise position and reposition ourselves.

The reactions are not fully developed in infants. Infants depend on adults to move them from place to place and to supply everything they need. At birth, infants are dominated by gravity. But their strong desire to move soon motivates them to begin practicing the activities that will let them move freely.

What are righting and equilibrium reactions?

Righting reactions are natural movements to keep the body aligned. These are the first to develop. There are two categories of body alignment: alignment of the head in an upright position, and alignment of body parts in respect to each other. These alignments begin at birth and are mature by about 8 months of age.

Righting reactions are involved in many movements. While in the tummylying position, your infant tries to raise the head to look around and see the world. When being held upright, the infant gradually learns to hold the head up in a stable position without props or supports. When backlying, your infant will turn the head to look at something, and the rest of the body follows. The infant has just rolled for the first time.

Righting reactions are responsible only for alignment, not for maintaining balance. Babies can pull themselves up into a standing position and stay standing with support before they are able to balance without support. And they can sit, if someone puts them in position, before they can get into and out of the sitting position without help.

Equilibrium reactions are natural movements that help maintain balance when the body is moving. They develop in an orderly way, from the most stable position—lying down—to less stable positions, such as standing up. Physical laws determine how stable an object is; the bigger the base of support an object has, and the lower its center of gravity is, the more stable the object will be.

As children go from lying to standing, their stability gradually decreases, because their base of support gets smaller and their center of gravity moves upward. As stability decreases, they need more internal control of balance in order to move against gravity. Equilibrium reactions make this control possible. The reactions begin at about 6 months of age, with the baby in the tummylying position, and continue throughout life.

When do these reactions develop?

Righting reactions

Neck righting—begins at birth. When the head is turned, the body follows in the same direction.

- Optical righting—begins at 2 months. The child uses vision to align the head when the body is tilted.

- Labyrinthine righting—begins at 2 months in tummylying, 6 months in backlying and 8 months laterally. When the body is tilted the head orients itself to a normal position.
- Body righting—begins at 6 months. When the head is turned the shoulders follow, then the hips.

Equilibrium reactions

- Tummylying—begins at 6 months
- Backlying—begins at 6 months
- Hands and knees—begins at 8 months
- Sitting—begins at 10 to 12 months
- Standing—begins at 15 months

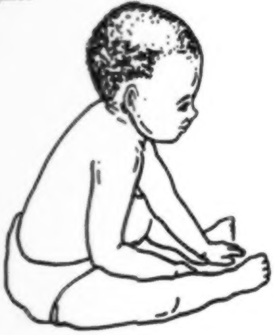
Considerations for Normal Sitting

by Barbara Hypes, P. T.

What is normal sitting?

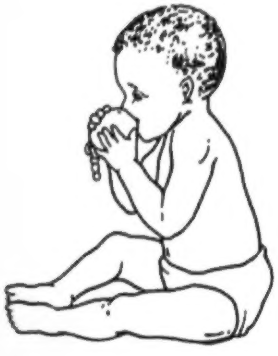
A child's normal sitting position is square on the bottom, with the pelvis—the basin-like bony structure forming the lower portion of the trunk, to which the legs are attached—vertical to the floor. To see how that feels, sit up tall in your chair and put your hands under your buttocks. If you feel the bones poking into your hands, your pelvis is vertical.

Until about age 6 months, your baby will sit with rounded back because the hip and back muscles are not strong enough to hold the baby upright.



At about 4 months, the baby will still be rounded in the back but can prop forward on the arms. With help, a 4- or 5-month-old is able to stay in the sitting position.

The child with normal motor control of the muscles and joints will sit alone, with back straight, at about 7 months.



The legs, in a ring position around the body, give a base of support for sitting. The arms are no longer needed as props, and your child can use them for play.

In normal sitting, children will fall forward or to the side; rarely do they push themselves backwards. As the back and hips get stronger, they practice sitting up and catching themselves as they fall forward. As sitting improves, they start to catch themselves as they move back and to the sides.

Until about 10 months old, your child will sit with knees bent. At about that time, the child will become able to *long sit*—with the legs straight out in front. Sit on the floor with your legs straight out in front; do you feel the leg muscles stretch? These muscles are tight until about 10 months; your child cannot sit with vertical pelvis and straight legs until the muscles stretch.

What are some ways for my child to sit independently?

Independent sitting means your child can sit without using the hands as props. Here are some of the ways your child can sit and keep the hands free for play:

Ring sitting—The legs form a ring shape. This provides a large base of support.

Long sitting—The legs are out in front with the knees straight.

Half-ring sitting—One leg is bent and one is straight.

Side sitting—Both feet are on one side.

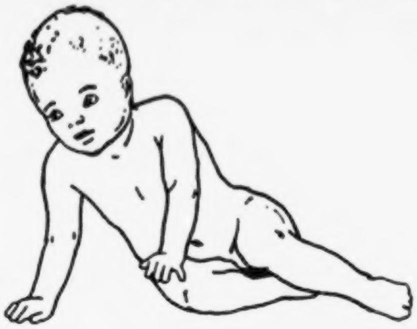
Tailor sitting—The legs are crossed and bent at the knees.

Heel sitting—The child sits on top of the feet.

"W" sitting—The child sits between the feet with the knees together.

Sitting control includes moving into and out of sitting positions. After 4 months, the child's head should not lag or hang behind when you pull the child up by the arms into a sitting position. The child should lift the head, tuck the chin into the chest, and straighten the knees.

While reaching for a toy from a sitting position, your child may fall forward or to the side. By 7 or 8 months, your child should start to play by rocking on hands and knees. Soon the child will move from hands and knees onto one side of the bottom, and then get into sitting without help.

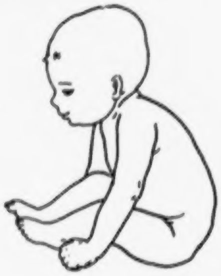


By 8 or 9 months your child should move over the legs from sitting and then up onto hands and knees. The child continues to practice moving up and over the legs to get into and out of sitting. The child also tries to get up to higher surfaces.

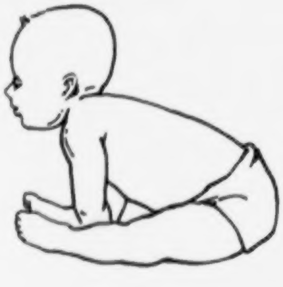
Should I get a professional opinion about my child's sitting?

See a doctor or therapist if your child:

- Sits on the back of the pelvis. Even when the muscles are tight, your child should sit with the pelvis vertical.



- Sits with legs squeezed together.
- Sits with legs so bent at the knees that the child falls over backwards.
- Is able to W-sit but cannot use any other position.
- Sits with legs so widely apart that the child collapses forward.



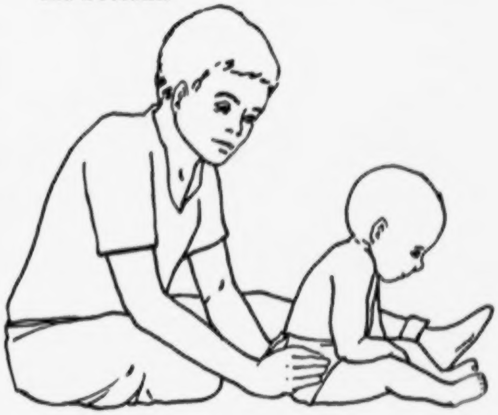
- Sits with the pelvis forward on the thighs with the lower back swayed forward.
- Always keeps hands down for support after age 6 or 7 months.
- Gets stuck in the sitting position and never moves into or out of it.
- Repeatedly falls unexpectedly while sitting. May tremble and seem fearful of moving. Occasional unexpected falls are normal.

How can I work on my child's sitting at home?

First, ask your doctor or therapist about things you can do at home. Here are some suggestions.

- To get the pelvis vertical:

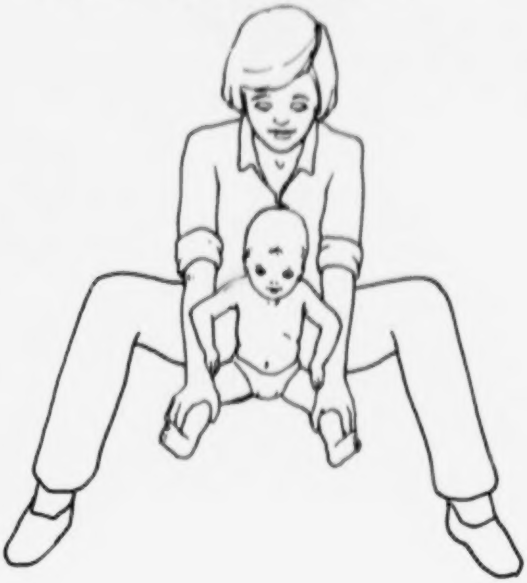
  Lift the hips so that the child is sitting on the bottom.



Have the child sit on a small wedge or on the edge of a blanket to lift the hips. To keep the back straight, keep the hips higher than the knees.

- To widen the base formed by the legs, keep the pelvis vertical and:

  Lightly hold the child's legs out.

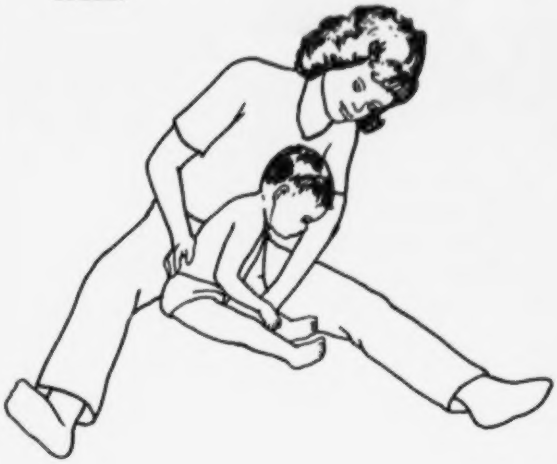


  Form the child's legs in a ring.

  Cross the legs into tailor sitting.

- When the child's sitting base is too wide, hold the legs together to make the base smaller.

- To straighten your child's back, support the pelvis and back with your leg or against a couch.



- To strengthen back muscles and hips, seat the child on a bench or wheelchair. Have the child reach down and then sit up.
- To free the arms for play, find sitting positions where the arms are not needed as props. The child can be propped up on the couch, supported on a bench, or fitted with adaptive equipment.
- Give your child a variety of sitting possibilities, such as on the couch, kitchen chair, bench, or bolster. Use adaptive equipment such as a bolster chair, posture chair, or wheelchair. Ask your therapist for other ideas on adaptive equipment for sitting.

The Developmental Sequence for Standing and Walking

by Barbara Cupps, P.T.

Standing and walking require balance and coordination. Your baby will spend many hours learning and practicing the skills needed to stand erect and move forward at the same time.

Babies develop at different rates and they don't all do things in exactly the same way. Some babies are content to sit and play longer than others. Very active babies may want to get up on their feet and try to walk very early. These individual traits don't indicate how your baby will develop in other areas. But there are some general stages you can look for.

Standing

Newborn infants have a reflex for stepping. They will take a few steps forward when held under the arms in a standing position and leaned slightly forward. This reflex is strongest at 3 to 4 weeks of age and usually disappears by the time the baby is 2 months old. Most babies don't try to put weight on their legs again for some time as they develop the muscle control needed for balance. They must lift their heads and gain control of their bodies in other positions before they stand.

By 3 to 4 months, babies start to take some weight on their legs again but have difficulty keeping their hips in line with their shoulders and feet. Their buttocks will wobble until they develop more control of the muscles in the lower trunk and hips.

At 5 to 6 months, babies love to be held standing and may move their bodies up and down as they are held. They will begin to stamp one foot, then the other. They are exercising the muscles they will use much later.

Between 7 and 9 months, most babies begin to experiment with pulling themselves to a standing position. This takes much trial and error. They pull with their arms on crib rails or playpen, getting their knees under them. Their bottoms rise off the surface and they plop back down. One day they will put one hand above the other and climb overhand until they are standing! They often scream at that point, because they don't know where they are or how to get down. Then they learn to lean their buttocks back, bend their knees, and sit down.

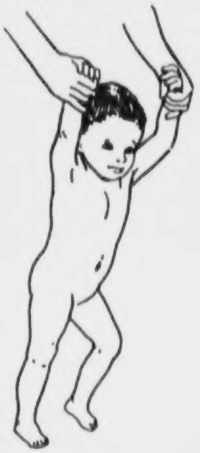
In the next few months, babies perfect their ability to move up and down from standing. They creep to an object, get on their knees, and pull with their arms. They put one foot up, then the other. They push up from squatting to standing. They even learn to do this with a toy in one hand. Babies practice moving from standing to squatting until they can lower themselves to the floor easily.

Babies teeter as they first stand alone, holding onto something for support. Some babies seem frightened; they cautiously develop standing control of their bodies. Other seem to be fearless and may even try to lunge from one support to the next. There comes a time when they want to stand for everything—they will stand in their high chairs, strollers, and shopping carts. They need to be watched carefully, as they will lean and topple over.

Most babies spend months holding onto things or leaning against furniture as they stand. This helps them to develop balance in an erect position. At first they hold on with both hands, then they lean and hold on with one hand. They might lean on their forearms and use their hands for play. They begin to twist their bodies sideways so they are leaning on one hip. They turn completely around and lean their buttocks against the sofa. All of this helps them to eventually let go and stand by themselves **at 12 to 14 months.**

Walking

Walking is very different from standing. **At 7 or 8 months,** babies again try to take steps when someone holds their hands. The movements will not be as coordinated as their early, automatic steps. Now they lift one leg high and try to put it down. The foot often lands too far forward and to the side. With practice, the steps will become more controlled and the feet will be closer together, as long as someone holds their hands.



As babies lean on furniture they will begin to take a step or two sideways. This early *cruising* is done with legs stiff. Then they learn to turn their bodies slightly and take a forward step. This becomes a very quick way of moving and soon they are walking from one piece of furniture to another.

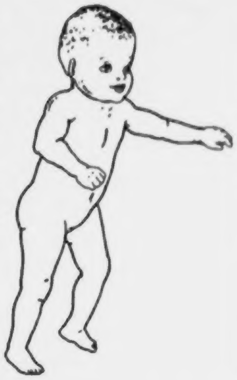
At 11 or 12 months, some babies will begin to experiment with pushing things such as chairs and realize that they can make them move. Let your baby push a sturdy kitchen chair or wheeled toy to practice stepping and balance.

A baby's first unsupported steps are often accidental: You let go as the baby is walking, the baby takes a step or two, realizes what has happened, and plops to the floor. Or the baby steps from one piece of furniture to another that is just beyond reach.

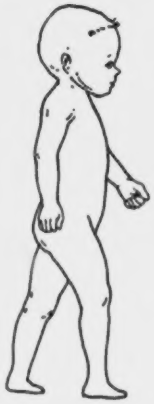
Or the baby is leaning on something, turns the upper body around, and takes a step. The arms spread like wings and a leg swings out, and the baby takes a step or two before falling.

Some babies take unsupported steps before they can stand alone. Others get their standing balance and slowly move one leg forward, adjust their weight and take another step. Within a week or so they are able to walk around a room. But walking takes all their concentration—to get somewhere quickly, they creep.

By 14 months, most babies walk independently. At first, they lift their legs high in the air. Their feet are wide apart and their arms are held up at their sides. As their balance improves, they will lower their arms and be able to carry a toy.



Some babies turn their feet out or in as they first try to combine balance with moving forward. They may walk on the inner edges of their feet or be up on their toes. Usually their legs and feet will look more normal when they have walked for awhile. The pediatrician should evaluate your baby after a month or so of independent walking. Most doctors recommend that early walkers go barefoot or wear soft-soled shoes. This is good exercise for the feet and lets the baby use the toes for balance.



As walking becomes steadier, the feet come closer together and the steps even out. Babies get the control to squat to the floor and pick up a toy, and they learn to stop and start at will. They are on their way to exploring in an upright posture. Toddlers need constant supervision, since their physical abilities are well beyond their understanding of danger.

Should my baby use a walker?

That's up to you. A walker can give an active baby lots of exercise, but it won't help your baby walk any sooner. It also keeps your baby from exploring by feeling and picking up things—your baby needs to get down to the floor to play and then get back up again. If you decide to use a walker, supervise your baby carefully—stairs can be dangerous, even ones with closed doors.

For more information
Princeton Center for Infancy and Early Childhood. 1980. *The first twelve months of life: Your baby's growth month by month.* Edited by F. Caplan. New York: Grosset & Dunlap.

Normal Foot Development

by Linda A. Kliebhan, P.T.

Why is foot control so important?

Think of all the ways our feet help us move. Imagine trying to stand, walk, run, or stand up from sitting or from being on your hands and knees—all without having control of your feet. Improper foot alignment or poor muscular control can also affect knee and hip control, and may even change your child's posture and ability to function.

What should a newborn's feet look and feel like?

Your baby's feet may turn slightly inward at the front and at the heel, because of growth and position changes in the womb. The foot flexes easily in most directions because the muscles are weak and the ligaments which connect the bones are more elastic than they will be later in life. The ankle moves through a full range of motion, from the toe-down position (*plantarflexion*) to the toe-up position (*dorsiflexion*).

How will my baby's feet change in the first few months?

Your baby's feet will begin to move in all directions. The movements will not be well controlled and will generally be part of total body movements such as stretching or kicking. These movements exercise the muscles and let your baby learn how it feels to move.

Gradually, the position of your baby's feet will change as the positions of the hips and knees change. In the first two or three months, your baby's legs will move apart when the baby is in a backlying or tummylying position, allowing the feet to gradually turn more outward.

How can I encourage normal movements and positions for my baby's feet during the early months?

Your baby needs to feel the feet move and to touch the feet to each other and to the surface. This is easier when lying on the tummy or back, so allow your baby to spend some time other than when asleep in those positions. Your baby can spend short periods of time on a blanket on the floor or, if necessary, in a playpen. Touch and gently massage your baby's feet to help your baby become more aware of them.

Will rolling and moving on the floor help my baby develop foot control?

From about 4 to 7 months of age, your baby will use the feet more actively in kicking and rolling. Your baby will begin *bridging*—lifting the bottom to put weight on the feet while backlying.

Another way for your baby to put weight on the feet is to put one foot on the floor while in a sidelying position. These activities strengthen your baby's feet and prepare them to accept more weight in the standing position. Your baby will also begin to touch the feet, bring them to the mouth, and pull on the toes. This makes your baby more aware of the sight and feel of the feet.

What else can I do with my baby during this period?

Have your baby spend time in the tummylying position. This lets your baby begin rolling and moving on the tummy and back. Your baby will probably explore the feet naturally, but you can help by bringing the baby's hands and feet together. Diaper-changing is a good time for this.

What happens when my baby starts standing?

At about 7 to 10 months, most babies begin to pull themselves up to a standing position. This often happens in the crib or playpen. At the same time, your baby will probably also be crawling on hands and knees and learning to move from hands and knees to sitting and back again.

All of these activities help make the foot muscles stronger. Don't worry if your baby doesn't at first always place the foot in the proper position for each activity; these trial-and-error experiences are an important part of learning. Your baby must learn to control the foot in all directions when weight is on the foot.

Why does my baby look flat-footed in standing?

Babies have large pads of fat under their heels, which makes their feet look flat when weight is put on them. Also, in order to feel more stable, babies stand with their legs spread widely at first. This places more weight on the inside of the feet and flattens the arch. However, the bony arch is still present and will look more normal as your baby narrows the base of support, strengthens the muscles, and learns to walk. It is not unusual for babies to look flat-footed until about age 2.

What happens to the feet during the cruising stage?

Your baby will begin to *cruise*—take sideways steps while holding onto furniture—soon after learning to pull to standing. This usually occurs from 9 to 12 months of age. Cruising gives support as your baby works to develop more control while moving in the standing position.

Foot control becomes more refined during this time and your baby will practice going up on the toes and coming down. Cruising changes as your baby develops better balance and control, so there will also be changes in the position of the feet as the body begins to rotate and the hip position changes. Your baby will begin squatting next to the furniture. This requires excellent control of the feet to balance the rest of the body.

Is foot control fully developed when my baby learns to walk?

During the early stages of walking, your baby will continue to strengthen the muscles of the feet and learn the subtle control of them necessary for a mature walking pattern. By the age of 2, the alignment and control of the foot for walking will be quite well developed.

Further refinements will occur as your child learns new skills such as running and jumping, but those skills are related more to balance and motor control than to the foot itself.

Will shoes help my baby's feet develop?

No! Shoes serve mainly to protect the feet in the early years. But they also limit what your baby feels with the feet, and they restrict motion in the joints. Babies and toddlers should be barefooted as much of the time as possible.

Summary

Your child's feet will go through many changes in appearance and control while your child learns to roll, crawl, stand, and walk. Alignment and control of the feet is critical for getting up from the floor, standing, walking, and running. The muscles of the feet will get stronger and start to work at the proper times. Ligaments will tighten and the normal alignment of the feet will develop as the feet grow. Your child's feet will be half their adult length by the child's first birthday.

For more information

Chase, R. A., J. J. Fisher III, and R. R. Rubin. Photographs by B. Parsons. 1984. *Your baby: The first wondrous year.* New York: Collier Books.

Fine Motor Development: The First Year

by Jeanne Sangirardi Ganz, O.T.R.

It's exciting to watch babies learn to use their arms and hands. By the age of 1, most of the foundation for hand usage has been established. Here's the development you should see during the first year.

Newborn

A newborn tends to keep the arms and hands tucked in close to the body in a position called *flexion*. The shoulders are rounded, elbows are bent, and hands are closed loosely. But the baby does not always stay in one position; the arms and hands can move a great deal as the baby kicks or is moved.

When your baby is in the backlying position, the hands will open and close and the arms will randomly swing out wide. Sometimes the hands land on the head, face, or ears, and the baby begins to learn about the body.

The baby touches and feels, and is soon sucking—and learning about—the hands. The newborn's arm and hand movements are not truly controlled; they usually occur in response to movement in the rest of the body. The newborn's grasp is a reflex—the hand automatically closes on objects the baby touches. This reflex, when baby clings tightly to a finger, is a favorite for most adults. The baby can feel but not control the grip.

1 to 3 months

Now the baby works hard to develop head and trunk control. The baby grows more able to hold the head steady in all positions and to raise it while tummylying. The arms and hands are busy, too, working to support the actions of the head and trunk. They push down to help the baby lift and balance the head. This control of the body also helps the arms and hands.

For good reaching patterns to develop, the baby must gain control of the trunk and the shoulder girdle (the muscles, bones, and ligaments that surround the shoulder and support the use of the arms). Increased head and trunk control lets the baby use the arms for reaching and playing rather than for support.

During the first three months, there are changes in the general position of the arms when the baby is tummylying. At first, the arms are tucked in close to the body with the elbows near the ribs.

By the third month, the elbows are almost in line with the shoulders. Now the baby can prop up briefly on the arms and can move them away from the body more freely. Arms can swing out to the side but not yet directly to the front. The baby's eyes can focus to the length of the arm; now the baby begins to look at this wonderful new toy, the hand. The grasp reflex helps the baby hold onto toys, if only for a moment.

By the third month, the baby will be bringing the hands to the chest, pulling on clothing, and playing with the two hands together. The baby learns the location of the midline—the center of the body—which is an important step for most play, self-care, and learning activities. The grasp becomes more controlled and voluntary and the hands can adjust to the shape of objects.

Early grasping patterns begin now and develop over the next months. At first, most of the activity or control is at the pinky side of the hand. Most of the grasping is in the area where the palm meets the fingers. The fingers follow around the object without being too active yet.

4 to 5 months

Head and trunk control have improved; now the baby can prop up on the forearms to look around. In this position, the baby can shift from side to side, which helps to develop the ability to turn the palms up and down. The shoulder girdle muscles develop as the baby pushes up and down and moves from side to side. By the fifth month the baby can push up onto straight elbows and shift the weight over the hands. This helps develop the small muscles of the hand, so that fine grasping patterns can develop.

Reaching patterns are developing, too. At first, the baby cannot reach while tummylying. With practice, the baby learns to reach with one arm while on the forearms and later while on an extended arm. The shoulder girdle and trunk are stable enough now for the baby to reach forward while backlying. At first the baby can reach only to the knees; the feet come within reach by the fifth to sixth month.

The baby can now use both hands together, one hand holding and one playing or bringing the toy to the mouth. Toys are fascinating, and the baby loves to play. The grasp is now more active at the middle of the palm, and the whole hand closes. The thumb is not too useful yet. The baby might be able to switch a toy from one hand to the other but the process will be a bit awkward, with a delay in the middle.

6 to 8 months

The next important step for the arms and hands comes when the baby begins to sit. Again, the arms and the body help each other. At first, the baby is unsteady when sitting and uses the arms and hands for support. Often the arms and shoulders are held high and flexed. When the baby learns to balance and sit steadily, the arms are again free to develop new skills.

By this time, all of the shoulder muscles work together to help the arms move smoothly. The reach is more accurate now, toys are easily switched from hand to hand, and the thumb moves in to help grasp. The baby is not able to control the tightness of the grip and usually presses hard on toys.

Now moving on to more advanced gross motor skills, such as crawling, the baby can better coordinate the arms and body. Fine motor skills are improving now, too. By 8 months the baby can reach out for objects and reach across the midline of the body without losing balance. The thumb can wrap around objects—now the baby can hold two small objects, such as cubes, in one hand. The baby loves to shake and bang toys, which helps develop the ability to let go.

9 to 12 months

The baby learns more about using arms, hands, and body together while pulling up to standing. Some babies start to walk now. The baby loves to explore objects and the surrounding area.

Games such as "so big" and "wave bye bye" are fun and help develop fine motor skills, too. Reaching overhead to show "how big" uses good sitting balance and exercises the low back muscles. Waving "bye-bye" practices wrist control, and "pat-a-cake" works on coordinating both hands at midline.

The index finger starts to move separately from the rest of the hand when poking at toys and faces. This leads to the pincer grasp, with the tips of the thumb and index finger meeting in a precise pattern. The pincer grasp is used to pick up small objects. The baby starts out using the thumb at the side and lower end of the index finger. Gradually the baby gets control of more and more of the index finger. A true pincer grasp appears at about 12 months.

The baby's ability to let go of an object smoothly has also improved. The 9-month-old uses the whole arm to drop an object. A slightly older baby can use primarily the hand and wrist to drop a cube into a container. At 12 months, some babies can release one cube onto another to build a two-block tower.

The 9- to 12-month-old may prefer one hand over the other. This can change; true "handedness" does not come until much later. The baby will still use both hands together and switch hands easily for quite some time.

The baby now has a basis for good arm and hand usage, but the skills will continue to improve over the next several years.

For more information

Chase, R. A., J. J. Fisher III, and R. R. Rubin. Photographs by B. Parsons. 1984. *Your baby: The first wondrous year.* New York: Collier Books.

Princeton Center for Infancy and Early Childhood. 1980. *The first twelve months of life: Your baby's growth month by month.* Edited by F. Caplan. New York: Grosset & Dunlap.

Perceptual-Motor Development in the Toddler

by Beth Witt, M.A.

What is perceptual-motor development?

Two aspects of a child's growth combine to produce perceptual-motor development. *Perception* is any process by which children become aware of what is happening around them. Children gain information through their senses—what they see, hear, smell, taste, and touch. As babies grow, their senses become sharper and more accurate, and their ability to perceive becomes stronger. They begin to *organize* their perceptions and make sense of them.

The increasing ability to control the movement of the body is called *motor development.* Little children learn to move different parts of their bodies as they get involved with the objects and people they perceive. This is called *perceptual-motor development.* The perceptual-motor process is an "in-out" process, since the information comes in to the mind, which then tells the body how to move in response.

The first years of life are very important in developing good perceptual-motor abilities. Educators call this period the *sensori-motor* period, because infants and toddlers spend so much time observing and reacting to their world through their senses.

What are some perceptual-motor milestones?

Newborn to 1 month: Babies use basic reflexes, present at birth, to respond to their perceptions. They suck, cry, and grasp. When awake, they look and hear; this is early perceiving.

1 to 4 months: To gain information, babies begin trying to improve their listening and looking. They try to refine their movements, such as thumb-sucking, to satisfy needs.

4 to 8 months: Babies begin to realize they can make things happen. They rub, strike, shake, and kick at objects to make them move, make noise, or produce new information for their senses. They try to hold onto and look at toys and body parts (such as hands and feet). Most importantly, their perceptions begin to become organized enough so that they develop *object permanence*—they've learned that an object still exists even when it is out of sight. They can mentally "hold a picture," a very important first step in learning to think!

8 to 12 months: Babies begin to move intentionally—the way they move is a means to an end. They pull strings and use sticks to pull in out-of-reach objects. They hunt for out-of-sight objects, crawling under tables and lifting covers. At this age, babies are fun to play with. They imitate simple actions (clapping, wagging tongue, lying down) and simple sounds and words ("ma-ma," "bye-bye"). Coordinating face, mouth, and throat muscles to imitate and produce sound combinations is a perceptual-motor response.

The *pincer grasp* is another important perceptual-motor ability that develops now. To use the pincer grasp, your baby must visually focus on tiny objects and put the thumb and forefinger together to pick them up.

1 to 1½ years: Babies are toddlers now and more able to get about. They are interested in learning how to move their bodies in different ways, such as walking, running, jumping, and climbing. They also explore objects to learn about them. They love to combine objects. They make a lot of noise and often a big mess as they "move to learn."

They respond to their perceptions with such motor responses as:

- Stuffing socks in shoes
- Trying to put on and take off pan and jar lids
- Stacking a couple of soup cans or blocks.

1½ to 2 years: These active little ones have now refined their perceptions into mental pictures with names. They've learned that many things go together. They know that things have function(s) and are usually found in certain places. Their motor responses are more planned and deliberate. And these babies can make their body parts move more efficiently for their purposes! They begin to see relationships when they put objects together.

They enjoy activities that help answer the simple questions they have. These could include:

- Fitting different-sized cups together
- Turning a crank to make a toy pop up
- Turning a key to make a toy move
- Fitting round and square blocks in simple formboards
- Scribbling with a crayon to see the marks.

2 to 3 years: By now, children have gained enough information through their senses and exploration that they begin to form ideas. They are learning to think effectively. However, they still learn much through their manipulation of objects and people. Their "percepts" (single thoughts) become "concepts" (combined thoughts). They learn that things can be a size (small) and a color (red). They learn things have more than one function (eat, cook) and have various parts (skin, pulp, stem, seeds). They combine words to try to describe their world and express their thoughts.

Children now **ask** for information as they move their bodies and objects:

> "What color is this?"
>
> "Where this go?"
>
> "Why this not have buttons?"
>
> "What you doing?"

They like to dress and undress dolls, put simple puzzles together, "string" objects, and manipulate clay and paintbrushes. Toward the end of the second year, they enjoy learning to fasten their clothing, mark with crayons, and snip with scissors. These activities require them to use both hands together. By the third year, their perceptual-motor development has involved **much** combined mental and physical growth.

What can interfere with perceptual-motor growth?

Many things can interfere with perceptual-motor growth. Deafness and blindness prevent children from perceiving important information. Not learning how things look or sound can interfere with developing good movement responses to them.

A lack of motor exploration of objects can also interfere with children's forming proper concepts about them, so children who are physically limited need special help with their perceptual-motor development. Mental disabilities, specific learning and language disabilities, and emotional difficulties can also interfere with development in this important preacademic area.

How can I help when there is a problem?

It is important to spot a problem early if your child seems unable to respond appropriately to people and objects. The earlier problems are taken care of, the better your child will grow, develop, and learn.

Sometimes medical attention is needed. Sometimes early special education and therapy will help. Don't assume your child will "grow out of the problem." Educators know a variety of ways to adapt training so that your child can move, look, and listen—and **learn**—as normally as possible.

Seeking such help is the most basic way you can help. By working with educators and therapists, you can help your child learn at home and school.

For more information

Honig, A. S., and J. R. Lally. 1981. *Infant caregiving: A design for training.* Syracuse: Syracuse University Press.

Cooke, J., and D. Williams. 1987. *Working with children's language.* Tucson: Communication Skill Builders.

Variations in Muscle Tone

by Linda E. Caldwell, P.T.

What is muscle tone?

Muscle tone refers to how tense a muscle is at rest. Tone prepares the muscle for movement and supports the muscle and surrounding structures as they move.

Tone is dynamic—it changes automatically, according to the situation. Your tone is probably lower when you are resting quietly than when you are cheering for the home team at the football game.

Some things that can influence normal muscle tone are:

- The level of emotional stress
- The level and kind of music being listened to
- The temperature
- The level of physical activity
- Inherited—genetic—traits.

Normal tone feels firm and allows muscles to be lengthened so the joints can move normally. It also helps the muscles move smoothly and voluntarily.

Muscle tone is monitored and controlled by the brain. The brain uses information from the muscles, from other parts of the body, and from what is happening in the environment to automatically adjust tone. Damage to the brain sometimes alters muscle tone. Tone may increase, decrease, or fluctuate, depending on the area of the brain that is damaged.

What are the different types of tone problems?

Rigidity is very high muscle tone. This tone holds the joints very tightly and does not allow movement. It is very difficult to move the joint, but when it is moved beyond an initial range the tone is released, and then there is very little resistance. This is known as "clasp knife rigidity." It is similar to closing a pocket knife—there is strong resistance at first, but then the blade snaps shut.

Hypertonus is the abnormally high tone known as *spasticity.* Spasticity results in a resistance to movement and in limited motion in joints. The muscle tone is so high that it prevents smooth, coordinated, voluntary movement. The child appears stuck in abnormal positions and moves in abnormal patterns. When another person tries to move a joint, there is resistance throughout the range of movement. Sometimes this resistance feels like pulling on a large rubber band.

Hypotonus is low tone and is often described as *floppy.* Low tone does not support the joint well, so the joints are loose and may be described as double-jointed. It is easy for another person to move the joint, and when the child moves, the child may seem weak and slow to respond.

Fluctuating tone (changing tone beyond normal ranges) is seen in **athetoid** types of movement. Athetoid means "without posture" and appears as random uncontrollable writhing movements. Athetosis makes fine motor and controlled movements in midranges very difficult. Once the movement has begun it is difficult to stop or to smoothly "grade." The dominant tone may be too high (tension athetosis) or too low (choreo athetosis).

Dystonia means abnormal tone. Most abnormal muscle tone caused by brain injury is of this "mixed" type. Tone is influenced by body positions; in dystonia, tone may be too high in some positions and too low in others. Sometimes tone is low in the neck and trunk and high in the arms and legs.

Is there any help available for my child?

The physiological and therapeutic significance of muscle tone is still not fully understood. Therapies, surgical procedures, and medications have been developed to attempt to alter abnormal tone and to allow more functional movement. Some treatments are moderately successful, but abnormal muscle tone caused by brain damage still cannot be completely corrected.

Therapists, physicians, and researchers continue to gather more information and to develop better treatments. Pediatric occupational and physical therapists can help you understand and work with your child's muscle and motor development.

THERAPEUTIC MOVEMENT ACTIVITIES

1: Infant Massage: The Loving Touch

2: Lifting and Carrying Your Child

3: Making Range-of-Motion Exercises Part of Your Child's Day

4: Incorporating Movement Activities into Your Child's Day

5: The Ball as a Tool for Home Therapy

6: Daily Activities for the Child with Low Tone

7: Daily Activities for the Child with High Tone

8: Daily Activities for the Child with Hemiplegia

9: Water Fun and Swimming

Infant Massage: The Loving Touch

by Miriam Galilee, Massage Therapist and Instructor

Before your baby was born you expected a smooth delivery, a healthy baby, and an easy move into your new job as a parent.

But your baby has been born prematurely or with medical problems. Or maybe mental or physical disabilities appeared later. Suddenly a host of professionals are a part of your life.

The doctors, nurses, therapists, teachers, social workers, and others all have important roles in the care of your baby, but you may feel left out—without a role of your own. You may be overwhelmed with appointments, directions, and guidelines as to how to touch, feed, hold, position, and exercise your baby. It's easy to feel lost, confused, and helpless.

What can I do?

One of the professionals caring for your child may suggest that you learn to massage your baby. Infant massage is a powerful way for you to create and build a deep, healing, loving relationship with your baby under difficult circumstances.

What is infant massage?

Infant massage is a system of touching and stroking your baby in a way that expresses love, support, and protection. It is a unique and specific way to create and strengthen a special closeness and awareness between parents and baby.

To survive, we need touching as much as we do food. Humans can go through life blind, deaf, and completely lacking the senses of taste and smell—but survival is not possible without touch.

Infant massage is a therapeutic and effective tool to promote your baby's health and well-being. It will establish you as an important member of the team of caretakers, and it will make you and your baby feel wonderful.

What are the emotional benefits of infant massage?

Massage helps you to welcome your new baby into the family. Your touch can tell your baby how life can be pleasurable, painless, and relaxing. It shows acceptance, tolerance, and love, and it can help create a sense of security, reassurance, and safety for your baby.

Bonding is perhaps the most profound and powerful of all human contacts. This first tie between you and your infant will help shape the way your child relates to the world throughout life. Don't worry if an early hospital stay separated you from your infant—bonding is an ongoing process, so it is never too late to bond with your infant. Some of the elements that create bonding are:

Eye-to-eye contact: The eyes are fascinating, compelling, and stimulating. Evidence suggests that a baby's vision starts working when the baby first sees the "bull's-eye" shape of the mother's eye and nipple. Some parents say they first felt a "belonging" with their baby when they gazed into each other's eyes for the first time. Keep steady eye contact when you massage your baby.

Touch: There seems to be a specific touch behavior when parents meet their newborn. They lightly massage, stroke, and touch with their fingertips.

Voice: Parents typically use a high-pitched tone when speaking to their newborn, which works well with the baby's sensitive hearing.

There is a strong link between your speech and your baby's physical response. When your baby moves to your voice, you are encouraged to communicate more. As you talk, sing, and coo to your baby during massage, the two of you are bonding.

Odor: Mother and infant can recognize each other by odor. The close contact of massage makes that link stronger.

Heat: The mother's body provides the exact temperature that the unborn baby needs for warmth and comfort. After birth, your warm touch helps create the closeness of bonding.

What are the physical benefits of infant massage?

Infant massage affects all systems of the body. Massage:

- Increases cardiac (heart) output
- Makes digestion and breathing more efficient
- Increases circulation and speeds up the development of the nervous system
- Increases weight gain and creates a deeper, better sleep
- Relieves stress, gas, and colic
- Increases body awareness for both parent and infant, and shows parents how much relaxation, stimulation, pain, and pleasure the baby can endure.

My child has special needs. Can infant massage help?

Yes! Before birth, your baby is tuned in to the mother's rhythms and routines—her sleep-wake cycle, the rhythm of her walking, the beat of her heart, her breathing, and her daily routine. After an ordinary birth, you can help your baby set an "internal rhythm" by following a steady routine in the early days.

But a hospital stay may be necessary if your baby is born prematurely or with a disability. Most hospitals give excellent medical care, but there is often little regard for the baby's need to establish an internal rhythm. Often, the lights are always on and the nursery is noisy. Under these trying circumstances, your baby may decide that:

> "It hurts to live."
>
> "I can't trust."
>
> "I can't get what I want."
>
> "Everyone is out to hurt me."
>
> "I am not good enough."
>
> "I can't make it."

Because infant massage is a routine—rhythmically repeated, done softly, painlessly, and lovingly—it helps your baby establish a sense of order, balance, calmness, and trust. Your baby learns that:

> "Life is good."
>
> "I'm perfect just the way I am."
>
> "I can trust."
>
> "Everyone is here to help me."
>
> "I'm going to make it."

For more information
International Association of Infant-Massage Instructors (IAIMI)
P.O. Box 16103
Portland, OR 97216-0103
(503) 253-9977

This nonprofit organization offers parent training in many U.S. cities. Write or call for more information.

These books are also good resources for parents:

Schneider, V. 1982. *Infant massage.* New York: Bantam Books.

Montagu, A. 1986. *Touching: The human significance of the skin.* New York: Perennial Library.

Klaus, M., and J. Kennell. 1893. *Bonding.* New York: Plume Books.

Lifting and Carrying Your Child

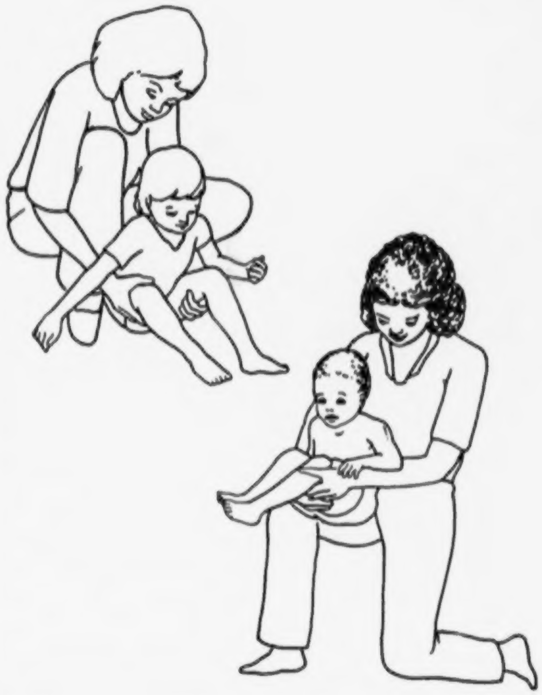
by Mary O'Connell, P.T.

Lifting and carrying even a small child can cause severe back pain if done improperly. Eight out of ten people can expect some degree of low back pain during their adult life, mainly because of poor posture and incorrect lifting and carrying.

By using the correct muscles, you let your legs—not the back muscles, which are much weaker—do the work. Back muscles protect the spinal column and permit walking upright; they're not designed for lifting.

Tips for safe lifting

1. Get help if you are in doubt about moving a child. A good rule of thumb is: Don't lift a child by yourself if the child weighs more than 35 percent of your body weight. If you weigh 120 lbs, don't lift a child who weighs more than 42 lbs by yourself. If you weigh 185 lbs, the limit would be 65 lbs.
2. Before lifting, separate your feet for better balance.
3. Get close to the child. Keep your back straight and bend your knees. Don't bend over!
4. While lifting: Keep the child close to your body as you straighten your knees. Keep your back upright.
5. Try not to twist your upper body. Turn by moving your feet, keeping your whole body straight.
6. Take your time and think about what muscles you are using.
7. Prepare for the lift by having the chair, mat, or equipment next to the child.
8. It is easier to lift a child from an elevated surface than from the floor.



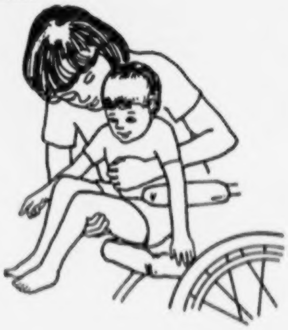
Lifting a child from the floor

1. Kneel in front of the child. Get as close as possible. Don't bend over with your legs straight.
2. For easier grasping, try lifting the child from behind.
3. Now place the child on or close to your leg, in a sitting position if possible. If the child is lying down, support at the shoulders and buttocks.
4. Straighten your legs to stand up. Keep your back straight.
5. Carry the child at or below your waist.

Lifting a child from a wheelchair or stroller

1. Make sure the brakes are engaged.
2. Remove all straps and seat belts. Stand close to the side of the chair. Bend your knees; keep your back straight.

3. Move the child as close to the front of the seat as possible.



4. Place one arm around the child's back, under the armpits or lower, and your other arm under the child's knees. Support the child's head with your body, if necessary.
5. Lift, keeping the child close to your body, holding the child in a chair position. Remember, **bend** your knees and keep your back straight. **Don't** lean over!
6. Ask for help if the child weighs more than 35 percent of your body weight. If two people are lifting, one person should lift the upper body, holding under the arms. The other should lift from under the knees or hips. The person lifting the upper body of the child has the heaviest load and should direct the lift.

Carrying the child

1. Try to carry the child at or slightly below waist level.
2. Use both arms to carry the child, if possible.
3. If you need to carry the child on one hip, alternate hips.
4. When standing for long periods while holding the child, elevate one foot on a small stool or other surface to prevent back strain.

Placing the child in the car seat

Placing your child in a car seat can be hard on your back!

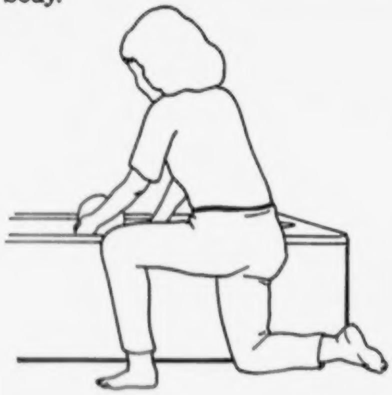
1. Don't twist your back when placing the child in the seat.
2. Place one or both of your knees on the seat of the car to help prevent bending your back.
3. You can also sit in the car with the child on your lap. Move to the side of the car seat to prevent rotating your upper body.

Diapering

1. Face the changing table squarely.
2. Don't bend or twist your back. If possible, raise the height of the changing table to avoid leaning over it.
3. When standing, try to elevate one of your legs on a small stool or block.
4. You can also slightly bend your knees to keep your back straight.
5. When lifting, remember to keep your back straight and bend and straighten your knees.

Bathing

1. Have all the towels and clothes ready and near the tub.
2. When bathing the child in the sink, elevate one of your feet on a footstool.
3. To place the child in the tub, face the tub and kneel as close to it as you can.
4. When lifting the child out of the tub, first place a towel on the edge of the tub and lift the child onto the towel. Then, move the child onto the floor by moving your whole body as a unit rather than using just your upper body.



These suggestions can help you to avoid a nagging back problem, so you can spend your time really enjoying your child.

39

Making Range-of-Motion Exercises Part of Your Child's Day

by Mary O'Connell, P.T.

Your child's physical or occupational therapist has recommended range-of-motion exercises for your child, but there never seems to be enough time to do them. Doing the exercises will be a lot easier if you make them a part of your—and your child's—daily routine.

What is *joint range of motion*?

Joint range of motion means moving a joint through its full available range of movement. Bones move and are connected to each other at a joint. When a joint is moved, the muscles, tendons, and ligaments that surround the joint are also moved and stretched.

Why are these exercises so important?

Children with disabilities may develop tightness in some muscles, which can lead to loss of active motion and possible permanent tightness or loss of movement. The child can't use tight muscles correctly, and the child's movement patterns can be impaired.

Range-of-motion exercises help to keep a joint and surrounding muscles, ligaments, tendons, and tissue from becoming tight or inflexible. The exercises also help improve blood circulation, promote bone growth, and improve the child's body awareness.

There are two types of range-of-motion exercises—*passive* and *active*. In passive range-of-motion exercises, someone else moves the joint. The child doesn't take an active part.

In active range-of-motion exercises, the child actively moves the arm, leg, or other joint. Someone else may help the child move the joint as much as possible.

How often should I do the exercises?

Range-of-motion exercises need to be done every day, but finding time is not always easy. You're much more likely to do the exercises if you include them as part of daily activities such as bathing, diapering, dressing, or carrying your child. You'll do the exercises several times as they fit into your day, rather than in one specific "exercise session." The exercises will be more fun for you and your child, too.

How should I do the exercises?

The physical or occupational therapist will review the specific techniques for doing range-of-motion exercises with your child. Be sure to practice with the therapist present until you feel confident with the methods.

In general, give gentle support *above* and *below* the joint you are moving. Do not push *on* the joint. Do the exercise slowly. Use a gentle touch and hold the joint at its stretched range up to a count of five. Do each exercise three to five times.

The exercise time should be a nonstressful, relaxed time for both of you. Bathing and massaging your child before exercising may further relax the muscles. Make sure that you and your child are comfortably positioned and that your clothing is not tight.

What if my child becomes upset during the exercises?

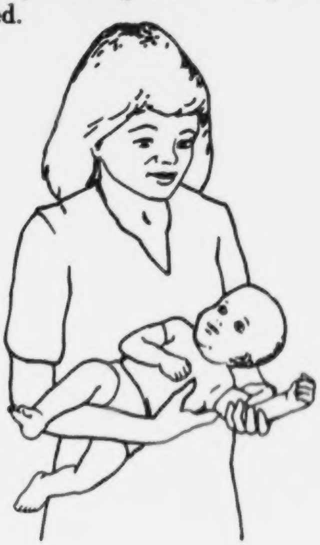
The exercises should not be painful for the child, but it can be uncomfortable to stretch tightened tissue. But without the exercises, the tightness, discomfort, and decreased function will get worse.

Start slowly and move the joint to the point where you begin to feel resistance. **Do not force the joint.** Move the joint only a short distance if your child begins to get fussy. Gradually increase the range in the joint, day by day. To distract the child, do the exercises as parts of games.

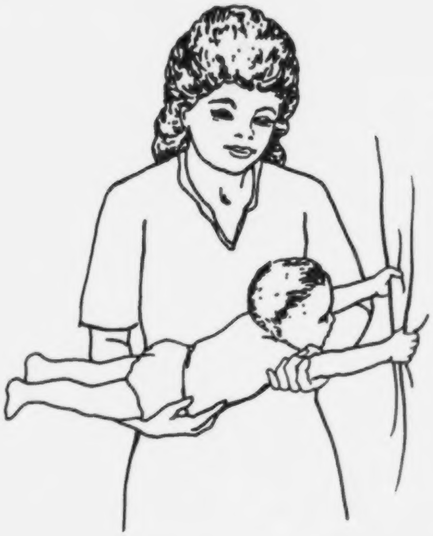
How can I make the exercises part of my daily routine?

You can include range-of-motion exercises in almost every activity you share with your child. Here are *some* examples; ask your child's therapist for more.

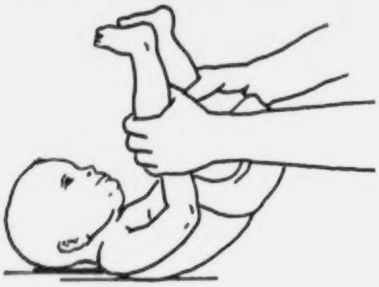
Carrying. Your child is facing forward. Stretch one side by holding one arm up and the legs separated.



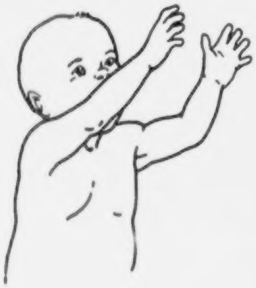
Stretch shoulders, back, and hips by carrying the child in a tummylying position.



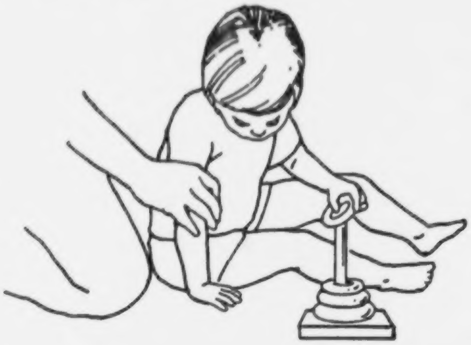
Diapering. Diapering can be a great time for a little range-of-motion exercise! Lift your baby's legs to stretch the hips.



Reaching. The way you offer a toy can encourage your baby to reach through the arm range of motion. This child is giving shoulders, elbows, and wrists that extra stretch.



Playing. This child is being supported in a sitting position while he twists to place the toy on the stack. His trunk is moving through its best range of motion on one side.



You and your child's therapist can come up with lots of other ways to do range-of-motion exercises as part of your daily routine. Make it fun!

41

Incorporating Movement Activities into Your Child's Day

by Mary O'Connell, P.T.

Movement activities play a very important role in a child's development. They allow the child to experience all sorts of new sensations and develop new motor skills.

The vestibular system

The *vestibular* system—the "movement" system—receives information from the inner ear and interprets it in the brain. The inner ear detects movement or a change in head position and sends the information to the brain. The brain uses the information to figure out where the body is in space.

The vestibular system automatically tells us if we are moving or if the room is moving, how fast we are going, and if we are right-side up or upside down. Many other nerve pathways in the brain are influenced by the vestibular system.

The vestibular system also helps to promote:

- Head control
- Balance reactions while sitting and standing
- Development of muscles which work against the pull of gravity
- Total body coordination
- Awareness of concepts such as *up, down, in,* and *out*
- Awareness of the self, especially when moving in space
- Smooth eye movements, which help eye-hand coordination
- Calmness, attention to task, and self-organization.

Normal development

We're all born with a desire to move. Children normally seek out and enjoy doing movement activities over and over as they play. Remember how much fun it was to swing high in the air, pretending you were touching the clouds?

A child's early experiences can affect how the brain develops. Stimulation develops movement and motor skills. The child who is left in a crib all day and not allowed to move alone on the floor is at risk for development delays. Even when stimulated, a child may continue to have problems within the vestibular or other neurological systems.

The movements a baby uses to explore—rolling, sitting, creeping, kneeling, and standing—are usually learned during the first year of life. The baby enjoys being held and rocked, swinging in a baby swing, bouncing on a lap, looking upside down, and being tossed in the air.

After about a year, the baby enjoys learning how to walk, climb, ride a tike bike, swing, creep up stairs, pull wagon toys, and run.

From 2 to 3 years of age, children enjoy swinging, climbing, slides, merry-go-rounds, piggyback rides, rolling down a hill, running, jumping, and riding tricycles.

How can I tell if my child is having vestibular system problems?

Sometimes a child's vestibular system will interpret information incorrectly. The system may be overactive, causing the child to be afraid of movement or react badly to it. Some examples are:

- Extreme car sickness
- Fear of swinging
- Fear of losing contact with the ground
- Fear of independent movement.

The system also may be underactive, causing the child to seek out more movement activities than normal, such as:

- Excessive spinning around
- Rocking back and forth for long periods of time.

Children vary in their responses to movement. But if your child seems to have excessive responses, consult your pediatrician.

Guidelines for movement activities with your child

Here are some movement guidelines that apply to children of all ages.

- The activity should feel good to the child.
- Do the activity in a relaxed, playful atmosphere.
- Talk to your child as you play together. Use simple one- to three-word phrases to explain what you are doing and to encourage the child to do more.
- To prevent injury to the child, make sure the activities are safe and supervised.
- Use slow movements to calm your child and fast movements to increase alertness.
- Changing the direction of a movement activity and abruptly stopping and restarting it will stimulate the movement system.
- If you move your child in one direction, remember to move in the opposite direction as well.
- Avoid activities that are too difficult for the child.
- Movements where the child is not in control can be threatening to a child and can cause the fear of movement to increase.
- **Stop immediately** if the child pulls away, becomes upset, or shows signs of nausea or dizziness. Consult your pediatrician or pediatric occupational or physical therapist if you are concerned about your child's ability to tolerate movement activities.

How can I stimulate the vestibular system?

With help from your child's therapist, do activities from the list below during your daily routine. Be sure to make the activity fun and playful.

Birth to 1 year

- Rocking child in your arms or in a rocking chair
- Bouncing child on your lap with child lying on tummy, sitting, and standing
- Moving child up and down while holding child tummy-down
- "Dancing" with your child
- Carrying child face-down
- Playing games such as "row your boat" with child on your lap on the floor
- Creeping over pillows, creeping on the floor
- Rolling on the floor
- Turning child upside down while holding child at chest level
- Bouncing in a baby seat
- Swinging in a baby swing
- Riding in a buggy
- Carrying child in a baby backpack
- Riding in a car
- Swimming
- Lying on a waterbed

1 to 3 years

- Playing on playground equipment—swings, slides, merry-go-rounds
- Playing on jungle gym and climbing, with help
- Riding in a stroller or wagon
- Riding a tike bike
- Riding a tricycle if child is able to pedal it
- Pulling child who is sitting on a blanket
- Pulling a wagon
- Swimming
- Rocking in a rocking chair
- Piggyback rides and horsey rides, with you on hands and knees
- Running and walking on different surfaces such as grass, carpeting, wide balance beam
- Rolling down a hill, rolling on the floor, rolling over pillows
- Bouncing on a waterbed, mattress, or trampoline
- Creeping into and out of large boxes
- Doing somersaults, with help

The Ball as a Tool for Home Therapy

by Barbara Hypes, P.T.

What is ball therapy?

You may have seen large inflatable balls scattered around the therapy clinic. The therapist may use them to work with your child.

Balls have been used in therapy for many years, first with adults who were paralyzed. Now the balls are used with younger people, too. Working on the ball helps increase strength, coordination, and blood circulation. It also helps increase range of motion by lengthening muscles to allow more movement in the joints. The result is a general improvement in physical conditioning.

The balls vary from 16" to 49" in diameter and are durable enough to hold lots of weight. They are springy, so they can be used for bounding activities and are comfortable for weight bearing.

What kind of ball can I use at home?

Good therapy balls are inflatable, made of molded vinyl that is thicker than the material used in beach balls. You can use a beach ball, but they tend to pop at the seams when overloaded. Your therapist can tell you where to get a good therapy ball.

How much should the ball be inflated?

The inflation can vary. A very full ball is taut and the surface is "quicker" and more challenging. With less inflation, the ball is loose and conforms to the body. This widens the base of support and slows the ball down.

Your child needs to feel secure on the ball. If your child is going to sit on the ball with little or no help, inflate the ball so the child's feet are on the ground and the hips and knees are bent at a 90-degree angle. If your child needs a lot of help on the ball, have the ball slightly soft so that it forms to the child's body.

Fill the ball with sand or water to slow it down and to change the way it moves.

What size of ball should I use?

Your therapist can help you decide on the best size for your child. Very large balls are nice because you don't have to bend down as far to work with the child. But big balls take up a lot of space, and the child cannot use one without help. Smaller balls are ideal for children, but you must be on the floor to help the child. There is no ideal size, but a 24" diameter ball is a good size for children.

Why is a ball such a good therapy tool?

The ball is **round,** so it moves easily in any direction. You can move the ball to get a movement in your child, helping your child be more active and alert. And since your child must react when the ball is moved—or else fall off—your child may have a more upright posture. But not necessarily; many children think it's fun to fall off the ball as long as they land safely.

The ball **rolls,** so your child can experience rolling in many different directions, moving in ways that the child may be too stiff or loose to do independently. The child can:

- Sit and be rolled forward and back, or side to side
- Lie face down and roll
- Lie face up and roll back until the head is upside down.

Your child may not be used to moving easily and smoothly. If rolling is scary, hold your child securely on the ball so the child feels safe.

The ball **bounces,** so your child can learn what jumping feels like. Your child can bounce on the ball alone or with your help. Try different positions—bouncing should be fun!

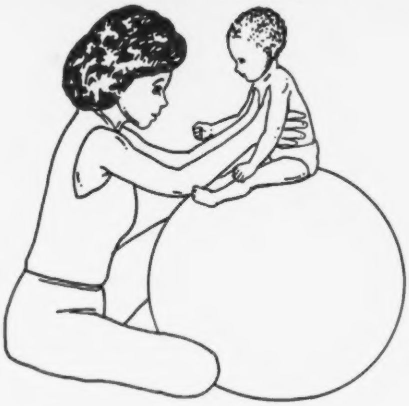
Your child can practice many other skills, too, such as throwing, bouncing, dribbling, catching, dodging, chasing, and hitting. The ball is a toy as well as a therapy tool.

What can I do at home with my child?

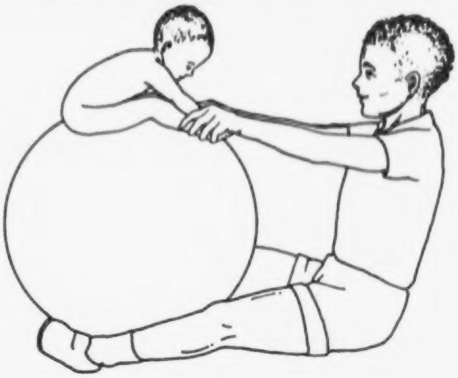
Here are some things your pediatric therapist can show you how to work on at home:

Changing your child's degree of stiffness. Ball therapy can help if your child is very stiff and difficult to move. Make sure your child feels secure on the ball—sit on the ball with the child on your lap, or closely support the child. Then rock the child slowly in all directions while you try to lengthen tight arms and legs. Move slowly and rhythmically so you don't startle your child.

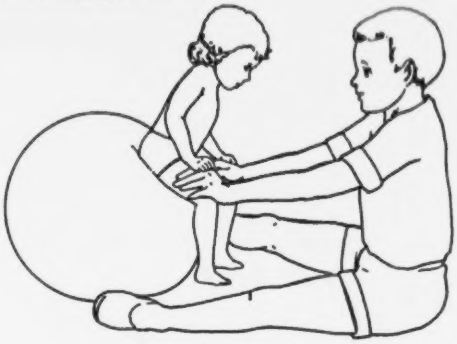
The ball can help the child who is too loose become more active. Again, your child needs to feel secure on the ball. With your child in any position, bounce the ball or move it in any direction. A loose child may respond more to quicker, less rhythmic movements.



Increasing or maintaining range of motion. To lengthen tight muscles, support your child's trunk on the ball and move the tight arm or leg away from the body. To *extend* the spine—to make it longer—have your child lie upside down on the ball. To lengthen the back hip muscles, help your child stay in a sitting position, then move the child backward as you hold the child's pelvis or hands and feet.



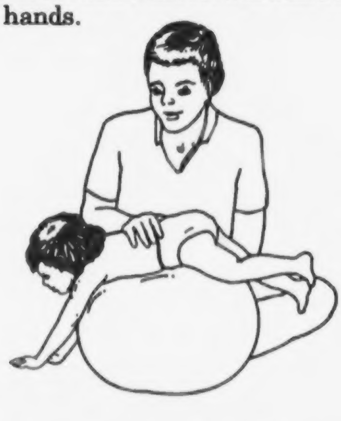
Helping your child change positions easily. Hold your child's arms or legs and help the child roll on the ball. Hold the child at hips or trunk and move the ball—this helps the child learn to shift weight while sitting. Put the child face-up or face-down and move the ball so the head is more upright, level, or upside down. This lets your child move in different planes, and teaches *up, down, side to side, upside down,* and *over and under.* To practice standing, your child can lean against the ball or stand up on it from a sitting position.



Increasing your child's strength. Trying to keep good posture while on the ball is good exercise!

Hips and back: Have the child sit tall on the ball and try to hold the position as you move the ball. Have the child lie face down and kick the legs up and down.

Shoulders and arms: Have your child take some weight on the arms and walk forward and backward on the hands.



Stomach muscles: Have the child lie face up on the ball. To help child sit up, hold child's ribs and lift.

You can do many other activities with the ball—work with your therapist to develop a program for your child. Don't always do the exercises on the ball; it's important that your child does range-of-motion, strength, and ease-of-movement exercises on the floor, too.

And keep it fun!

Daily Activities for the Child with Low Tone

by Barbara Tracy, P.T.

Low muscle tone can make it difficult for your child to move and play. A child with low tone often seems passive and unmotivated, and may feel limp and heavy when held. Therapy can help your child gain the strength and mobility needed for independence.

Taking your child for physical or occupational therapy can be a positive and rewarding experience for you as a parent. You can see your child working hard and learning many new skills. Often, the therapist will suggest activities for a home therapy program. It's important that you work these suggestions into your daily routine—the more your child practices, the sooner the activities become a part of everyday life.

You can turn many everyday activities into exercise times. You can do a lot as you dress and undress your child, during meals and baths, and even when you are just holding and carrying your child while you do other activities. Discuss the suggestions in this article with your child's therapist to make sure they're right for your child.

Dressing

When dressing your child, first consider the child's position. Sitting on your lap will let your child see what's happening and help improve trunk strength and balance. Move the child toward your knees, so the child can't lean on you for support. When able to sit without help, have your child sit on the floor to dress. A bench or small chair is even better. If you use a bench or chair, be sure that the child's feet are resting on the floor for security and balance.

A bench is ideal because your child can lean forward to reach for clothes, developing strength and coordination in the trunk. Leg strength improves as your child stands up to pull pants on or off. Have your child do as much as possible; help only when necessary.

Feeding

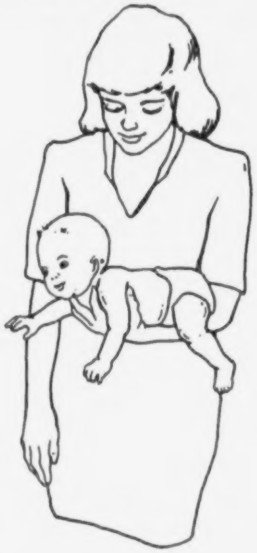
Make sure your child is in a well-supported position. If in a highchair, place your child in an upright position. Use a safety belt across the front of the pelvis to keep the bottom back in the chair. Use rolls or pieces of foam along the sides of the legs to keep them straight.

Bring the spoon toward the mouth from a position slightly lower than the mouth. Have your child come forward to the spoon—this helps to develop strength and balance control of the trunk.

Carrying

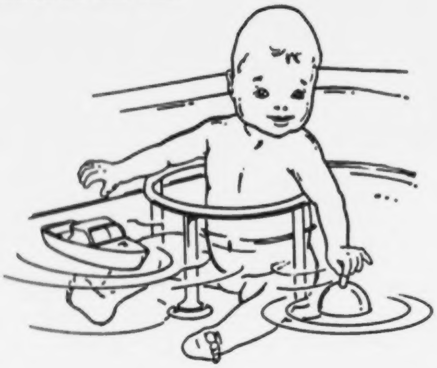
The very young infant with low muscle tone requires extra support and special attention to the head when being carried. As your child becomes older and develops head and trunk control, use carrying positions that make the child less dependent upon you for support, and avoid positions where your child sinks into your body. Turn your child to face away from you. Give support to the trunk only as necessary, keeping the child's legs together.

Another way to carry your child is in a football carry, with your child straddling your arm in a face-down position. Support the head as needed. In this position, your child can work on lifting the head against gravity.



Bathing

Bath time is a good time for developing strength because water resists arm and leg movements. Be sure your child is sitting in the tub with adequate support. Use tub rings, a towel on the bottom of the tub, or rubber mats to provide support. Never leave your child unattended in the tub.



There are many tub toys on the market which will both amuse and help your child. Sponge toys hold water and become heavy; lifting them helps develop arm strength. Give your child lots of toys and allow extra time for playing in the tub.

Vigorous washing with a washcloth and drying with a terry cloth towel help stimulate muscle tone and increase tolerance to touch. Be sure to rub around the face and especially the mouth, as this is a sensitive area for children with low muscle tone.

Diaper changing

While changing diapers, bring your child's feet up towards the hands and mouth for play. This improves your child's body awareness and lets your child explore and touch the legs and feet. Bringing the feet to the mouth also exercises the stomach muscles. Help by lifting your child's bottom off the surface a few inches and letting the feet fall toward the face. Don't let the legs fall out to the sides. When cleaning the child's bottom, keep the legs together and roll them from side to side. This will rotate the trunk and help teach your child how to roll.

The older child

Think of ways you can involve your child in your daily activities. The more activities your child participates in, the stronger the muscles become and the more independent your child will be. As you carry your child around the house, have the child reach for light switches or touch objects on the wall.

When you hold your child in your lap, work on trunk balance by gently rocking your legs from side to side or bouncing them up and down. Give only the support your child really needs; encourage active use of muscles for self-support.

As your child becomes more independent around the house, keep working to develop strength and improve overall balance and coordination. Give your child a laundry basket to carry; if your child can't carry the basket, it can be pushed or pulled when it is full of clothes or toys. Give your child a broom or rake and ask for help sweeping or raking. When outside, get a bucket of water and a large paintbrush and have your child paint the trees, sidewalk, rocks, or driveway. Ask your child to help with dusting the furniture or washing the car.

These activities will challenge your older child to strengthen muscles and refine balance and coordination. Be sure not to make jobs so hard that your child is frustrated. Keep testing your child's abilities; give just enough resistance to promote independence.

Daily Activities for the Child with High Tone

by Shelley Trimble, P.T.

Children with high postural tone, or *spasticity,* are stiff. They have trouble freely moving their heads, arms, and legs. Often, these children have low tone, or floppy, trunks. Motor problems like these can result in a *developmental delay* by preventing the child from developing as quickly as other children. If your child has a developmental delay, occupational therapy, physical therapy, speech/language therapy, or a combination of these can help.

Children with high tone tend to move in the same patterns over and over again. They need to experience a variety of movements, so look for ways to get your child to move in different patterns.

Many families today have busy, active lifestyles. Daily routines such as eating, dressing, or bathing can make it difficult to follow a therapy program. Here are some ways you can give your child movement experiences as part of everyday life. Every child has unique needs; be sure to consult your child's therapist(s) before trying these activities.

Any activity you do with your child should promote normal movement patterns. Stop any activity that results in abnormal ways of moving. Talk with your child's therapist about how to adapt the activity for your child.

Mealtime activities

Try this before or after mealtimes, or whenever you are working in the kitchen.

1. Let your child help or watch as you make your child's favorite instant pudding.
2. Position your child in the chair you and the therapist have chosen for mealtimes.
3. Plop a scoop of pudding on the tray or table.
4. Help your child "finger paint" with the pudding. Your child should use both hands, if possible.
5. Make sure to talk about what the child is doing. Describe the activity.

Here are some ways to change the activity:

- For different textures, put pudding on wax paper, foil, or a vinyl place mat.
- Use gelled gelatin instead of pudding.
- Try dry gelatin with water added. For a different sensation, add an ice cube and watch it melt.
- Use cornstarch for a powder effect. This helps your child's hands move freely. Add water to cornstarch for an interesting sensation.

Bath-time activities

Bath time is a wonderful time for your child to use and respond to different senses. The water gives a feeling of floating and free movement. The washcloth lets your child feel a rough texture. Bubbles in the tub move and touch the skin in different places.

This is a natural learning time. Here is one way to use it to help your child learn new ways to move:

1. Put your child in the position you and your child's therapist have chosen for bath time. Try to keep your child comfortably warm while bathing. Cool air or water temperatures may increase spasticity.
2. Squirt some shaving cream on the side of the tub, tile, or shower glass.
3. Help your child squish the shaving cream between fingers and hands. Smear the cream around and experiment. Encourage the use of both hands.
4. Look for ways to achieve other therapy goals. For example, if your child needs more trunk rotation, set up the activity so that your child must twist the trunk to reach the shaving cream.

Here are some ways to change the activity:

- Tint the shaving cream with food coloring.

- Use finger-paint soaps. Encourage your child to paint various body parts.
- Draw shapes, letters, numbers, etc., and have your child "erase" them.

Use a bubble wand and soap bubbles in the tub. The water helps keep the bubbles from popping. Have your child reach in different directions to pop the bubbles.

Play-time activities

It is important to play with your child every day. It's also important for your child to do some activities without much help from you—this promotes independence and builds self-confidence.

Consult with your child's therapist and choose a variety of positions that let your child use the head and body in the most functional and normal ways. Change the position every 20 to 30 minutes.

Choose toys that are light and easy to move. Toys that provide unexpected or varied responses are excellent. Some good ones are:

- Lightweight balls
- Balloons
- Beans and rice in a tub
- Bubbles
- Sponges in water
- Sandbox activities/toys.

If your child has difficulty using toys, ask the therapist about battery-operated toys that are turned on with a switch. These may let your child play independently for the first time.

Vary the way you give toys to your child. Children with high tone usually play with toys the same way over and over. You may be able to change the way your child plays with a particular toy by offering it in different positions, or putting it in different places in relationship to the child.

Introduce new or unusual toys. If your child is stuck on playing with a toy in an inappropriate manner, put that toy away and give an unfamiliar toy. Help your child learn to play with the new toy in a way that is appropriate to your child's developmental needs. Ask the therapist for ways to do this.

For more information

Finnie, N. 1975. Handling the young cerebral palsied child at home. New York: Dutton-Sunrise.

Daily Activities for the Child with Hemiplegia

by Shelley Trimble, P.T.

Children with hemiplegia have spasticity, or tightness, on one side—the *more involved* side—of the body. They hold this arm stiffly, and often walk on the toes of the foot on this side. They have trouble moving the arm and leg on this more involved side. They tend to overuse the less involved arm and leg and ignore the more involved limbs. This can lead to further stiffness in the trunk and limbs and can prevent the development of normal motor skills.

Your doctor should recommend therapy if your child has a motor problem such as hemiplegia. Physical therapy, occupational therapy, speech/language therapy, or a combination of these may help your child develop as well as possible. Therapy should start as early as possible; it's easier to change movement patterns before they become well established.

Children with hemiplegia need to develop *symmetry*—equality—to their movements. The two sides of the body need to become more alike and be able to work together. The more involved side needs to carry weight and move freely, while the less involved side needs to become less active.

The busy lifestyles of many families today can make it hard to follow a daily program of special therapy. Here are some ideas for *bilateral* (two-sided) movements that you can work into your daily routine. Every child has unique needs; check with your child's therapist(s) before trying these activities so they can be adapted to work best for your child.

Any activity you do with your child should promote normal movement patterns. Stop any activity that increases abnormal ways of moving. Brainstorm with your child's therapist on how to make the activity a successful one for your child.

Bath time

This is a wonderful time to promote activities—water encourages splashing and free movement. Here are some ways to do therapy at the same time:

- Squirt toys promote two-handed play. Place the toy in the more involved hand and allow your child to use the less involved hand to draw water up into the toy and squirt it. Or the toy could be held in the less involved hand. In this case you would probably need to help the child use the toy.
- Brightly colored sponges encourage the use of both hands. It's fun to "trap" the floating sponges and wring them out.
- Using a toy fishing rod and reel is a two-handed job. Place the rod in the more involved hand and your child can work the reel with the other. If your child's more involved hand is typically fisted, the dowel shape of the rod will keep the hand somewhat open. Plus, "hooking" the fish helps develop eye-hand coordination.
- Squirt shaving cream on the sides of the tub, tile, or shower glass. Encourage your child to use both hands to smear the cream into pictures and designs. Or tint the shaving cream with food coloring—or use colored bath paints— to draw a picture for the child to erase.

Mealtime

Put your child in the position you and your therapist have chosen for mealtimes. Put the plate and cup at the center of the child's body—not toward the less involved side. Put eating utensils on the side toward the more involved arm. Don't expect the child to pick up the utensils with the more involved arm, but this position will promote crossing the body with the less involved one.

To make it easier for your child to eat without help, use plates and bowls with suction bottoms. Or cut a suction-cup bath mat to fit the eating surface.

Try a scoop plate or bowl. These have a lip which makes one-handed scooping easier.

A cup without handles may encourage the use of both hands—cups with one or two handles are easier to use with only the less involved side.

Does your child have increased tone in the more involved arm (such as fisting of the hand or pulling back at the shoulder)? Use a suction cup or C-clamp to attach a dowel rod to the table. Help your child hold onto the dowel with the more involved hand. Position the dowel so that it brings the entire arm out of the abnormal pattern. Your therapist will tell you if this is a good idea for your child.

Play time

A magnetized bingo set makes a great two-handed toy. Put the wand in the less involved hand and have your child reach for and pick up the chips. Then have the child scrape the chips off with the more involved hand. If you put the wand in the more involved hand, it will act as a dowel, keeping the hand from fisting. **Do not give this toy if your child puts things in the mouth.**

Sandbox or sandtable play encourages the use of both hands. Your therapist can suggest good, active positions for your child. Tubs filled with rice and beans can also provide fun touching experiences and encourage two-handed play.

A beach ball is a low-cost toy that can help to develop symmetry (both sides doing the same thing). Encourage your child to use both arms to roll, throw, or catch the ball.

Kicking the ball requires shifting weight onto one leg so that the other leg is free to kick. If the child kicks with the less involved side, the more involved side is bearing weight, which is important for the development of motor skills.

The child gets free, active movement by kicking with the more involved side. This is also good. Ask your therapist if this activity is good for your child, and how to help your child do the best kicking possible.

Here's another beach ball activity:

Place your child on the ball, tummy down. Give support at the hips. Bring the child forward into the wheelbarrow position—hands on the floor with the arms carrying some weight. If the more involved hand is fisted, weight bearing should inhibit the tone and the hand should relax open. If your child has a weight-bearing hand splint you may want to use it during this activity.

Other fun bilateral activities

- Finger painting or pudding painting
- Playdough play
- Pull-apart beads
- Stringing toilet paper tubes on thick rope
- Using both hands to lift a toy overhead and in various directions
- Pushing a toy shopping cart or wagon

For more information

Finnie, N. 1975. *Handling the young cerebral palsied child at home*. New York: Dutton-Sunrise.

Water Fun and Swimming

by Caroline Larson, O.T.R.

Water is a part of life for every child. The fetus is surrounded by water. The infant is calmed by a warm bath, and toddlers love to splash and use toys to explore floating, sinking, and pouring. Most children enjoy going to a local pool or swimming area.

Can a pool program help children with special needs?

Yes! Children with physical disabilities or developmental delay can often move more freely in the water. In a shallow pool, some children are able to walk without crutches or braces. A warm pool helps relax tight muscles, too, and playing in water helps develop strength and coordination.

Breath control activities such as blowing bubbles are a part of every swim program. Learning better control of the lips and breathing may help with developing speech skills.

Why start so young?

Tot swim programs teach safety skills such as floating on the back or blowing bubbles. Most older children resist lying on their backs in the pool, but a young child will easily float face up. Without fear of the water, infants easily learn to hold their breath, and swimming movements come naturally.

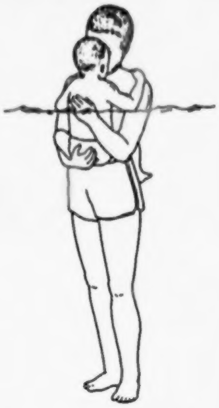
Infants who are comfortable in the water succeed as independent swimmers later on. As your child grows, swimming can be an important recreational activity. Swimming is a way to stay fit, control weight, and have fun—competitive swim meets are held for people with special needs, and swimmers can do other water sports, such as boating and scuba diving.

Where can I find a swim program for my child?

Check with local pools in your area. Parent-tot programs introduce children to water in a way that's safe and fun. Usually, these programs don't teach independent swimming, but older toddlers can attend group classes. For swim programs for children with disabilities, contact your local Easter Seal Society, United Cerebral Palsy Association, Association for Retarded Citizens, or local college.

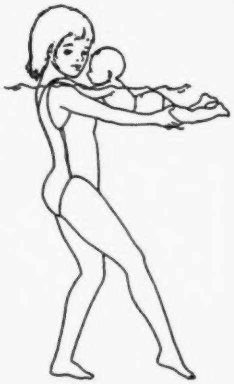
Entering the water

Your child may be timid about going into the pool, so spend some time together at home in the bathtub or in a small plastic pool.



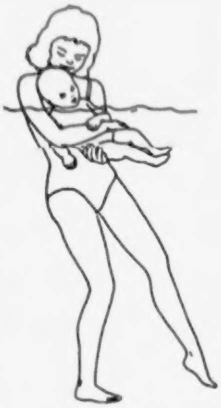
Bring familiar bath toys, plastic bowls, and sponges when you go to the pool for the first time. Let your child play at the edge of the pool while you stand in the water. If there are stairs, the child can play in shallow water. Don't rush—when your child is ready, enter the water gradually, supporting the child close to your body in **the straddle position.**

Once your child is comfortable in the straddle position, experiment with other positions.



Use **the face-to-face position** to teach your child to kick while facing downward. Have the child face you with hands on your shoulders. Hold the child at the hips or thighs and gently push the child's body away from you. Keep the hips lower than the head. Keep your child's shoulders under water. The child's chin should be in the water. Encourage kicking by moving the child's legs as you walk backwards. Move only when the child kicks, to show that kicking is a way to move in the water.

The back position helps your child learn to float face-up. Turn the child to face away from you. Put your right arm over the child's right



shoulder and across the chest, with the child's head resting on your right shoulder. The child can hold onto your right arm. The child's shoulders should be in the water. Use your left hand to support the child or help the legs to kick—encourage arm movement and kicking by walking backwards when the child moves the arms or legs.

Getting ready to swim

Diapers: Instead of diapers, use plastic pants under the swim suit. Disposable diapers dissolve and cloth diapers get too heavy.

Water temperature: should be above 88 degrees F. Begin with a hot shower if your child gets chilled in the pool. A T-shirt or tights, bathing cap, or wetsuit helmet or jacket will keep your child warmer. Bluish lips and chattering are signs of chilling—take a warm shower and return to the pool for short periods.

Ears: Many children with special needs have frequent ear infections. Ask your pediatrician if your child's ears should be submerged. Children with tubes in their ears should never go under water. Your doctor may suggest earmolds or putty-like material to keep water out of ears.

Skin: Pool chemicals can irritate skin, so shower after swimming. After showering, rub the skin with cream or petroleum jelly.

Children with conditions such as spina bifida may not feel pain in their legs or feet; they should wear socks in the pool to protect their feet.

Some children are very sensitive to the feeling of being surrounded by water. They may be more comfortable wearing a long-sleeved shirt in the pool.

Hair: In cold weather, bring a portable hair dryer.

Braces, splints, and other devices: Ask your doctor if your child's medical appliances can be worn in the pool. Use a safety strap on glasses. Hearing aids should not be submerged.

What about flotation aids?

It is important for a beginning swimmer to be in the water without the help of a flotation aid. Some aids limit arm movement, and many don't allow freedom of movement in all directions.

Once a child has mastered the basic skills, flotation aids may allow the child to be independent. Never leave a child using flotation aids alone. Flotation aids should be used only for short periods of time—it's best if your child learns to *swim*.

For more information

American National Red Cross. 1977. *Adapted aquatics.* Garden City, NY: Doubleday & Co. Inc.

Association of Swimming Therapy. 1981. *Swimming for the disabled.* London: Adam & Charles Black

Newman, Virginia. 1976. *Teaching an infant to swim.* San Diego: H.B.J. Publishing

Equipment resources

Danmar Products, Inc.
2390 Winewood Ave.
Ann Arbor, MI 48103

Equipment Shop, Inc.
P.O. Box 33
Bedford, MA 01730

Flaghouse
150 N. MacQuesten Pkwy
Mt. Vernon, NY 10550

THERAPEUTIC EQUIPMENT

1: Choosing a Wheelchair

2: Homemade Equipment for Lying

3: Homemade Equipment for Sitting

4: Homemade Equipment for Standing and Mobility

5: Mobility Aids

6: Your Child's Gastrostomy Tube

7: Your Child's Tracheostomy

Choosing a Wheelchair

by Timmie Wallace, P.T.

Buying a modern wheelchair is a lot like buying a new car—by choosing or rejecting models and options, you can create a chair that closely matches the user's needs. Here are some things to keep in mind.

Why use a wheelchair?

- When temporary or permanent physical conditions make walking impossible
- When walking is so difficult that it leaves no energy for other activities
- When you want to help your child develop the motivation to get around more conventionally—by walking.

Types of wheelchairs

There are a number of different wheelchair designs, in several general categories.

Stroller/travel chairs: child is pushed by another person

Manual and self-propelled: light-weight; sports; heavy-duty; one-armed drive; lever-operated

Power (battery) driven: conventional; scooter or "golf-cart" type; heavy-duty, all-terrain vehicles ("ATV"-type)

The team process

Selecting the right wheelchair is a team effort. Include everyone who will be involved in the use of the chair: you; your child; physical, occupational, and speech therapists; teachers; and the equipment vendor.

The opinion and needs of every member of the team is important:

The user needs comfort, ease of use, and reliability. Does the chair help to gain or improve function? How easy is it to transport?

The family needs reliability and a good appearance. How easy is the chair to transport? How easy is it to fold and to put together?

People at school/work need accessibility, maneuverability, and a good work surface. How large is the chair? How heavy is it? Will the design of the school/work building make it hard to use the chair?

Therapists are concerned with how well your child can use the chair without help and whether it can help your child develop fine motor skills, perceptual skills, and responsibility. If your child uses a communication system, does the chair have a tray to hold the system?

Where and how will the chair be used?

Indoors? Outdoors? Rugged terrain? At work, or for social activities? Do other "assistive devices" need to be with the chair for your child to function as well as possible? (Some assistive devices are: communication systems, electronic switches to operate devices that help with fine motor function, tray to hold supplies, back or side pack for extra equipment. Not all chairs will accept these extras.)

The wheelchair must go anywhere the child needs to be: work station or desk, in and out of buildings, through doorways and over thresholds, across paved and unpaved outdoor areas, around furniture and through hallways, and into all rooms at home and/or at work—including the bathroom.

Wheelchair transport

How easy will the wheelchair be to transport? Some "travel chairs" are disappointingly hard to transport.

Many of the newer sports chairs for children are light and easy to fold, but still take up room in the trunk or back seat. Wheelchair carriers—similar to bicycle carriers—save valuable space, but may not hold a power chair.

Taking care of the chair

Here are some questions to discuss with all team members *before* you choose a chair:

- Who will be responsible for the upkeep of the chair?
- How will decisions be made about changing the chair to allow for your child's growth?
- How long will adjustments or repairs take?

- Can you use a "loaner" when the chair is in the shop?
- Who makes sure the basic parts—such as tires, brakes, upholstery, and foot plates—are in working order?
- How much will changes or repairs cost?

Wheelchair growth

The wheelchair needs to "grow," because your child is growing and because the child's needs and environment get bigger every day. Can you adjust the chair to fit the changing needs of the child? How will that affect the work environment?

For instance, changing the chair's crossbars to allow for growth also changes the height of the chair, so you may need to adjust the desk, too. How long do you expect the chair to last? Can you trade in the chair if your child's needs change before the chair is worn out?

Options and extras

Society is changing. People who use wheelchairs are more likely to go out in public now. Buildings are being designed or modified to make them easier for wheelchair users. And people with disabilities are active in all areas of life, including sports. Wheelchairs are being designed to work in nearly every setting, and more options are available now than ever before.

Here are some of the choices you can make to make the chair best for *your* child:

Arm rests: standard, desk-type, removable, adjustable

Leg rests: elevating, swing-away, lift-off

Foot plates: lift-up, swing-out, large or small plate, with or without loops, cut-away to make room for the front wheels

Wheels and tires: one-armed drive, spoked, rubberized, pneumatic, "mag" wheels, solid rubber tires

Brake type and placement: forward lever for braking, backward pull for braking

Type of seat and back: standard chairs come with a soft, sling-type back and seat. These seats don't give much support, so good positioning is almost impossible. Sling-type seats can even limit how well your child is able to function. A firm or solid seat and back gives much better support but may interfere with folding the chair. If your child requires a special seating system, you can order a chair without a seat and back.

Summary

Here are some things to consider when you choose a wheelchair:

- Will this chair help my child be more independent and more able to function? Self-esteem, motivation, and psychological acceptance all depend on how well your child can use the chair.
- Who will be involved in the use of the chair? Does this chair satisfy their concerns?
- Who will maintain the chair? What will repairing and adapting the chair cost?
- What about safety features? (Seat belts are not standard equipment.) Is there a safety program available?
- Part of the equipment dealer's job is to tell you what options are available for different chairs. Be an informed consumer—don't buy a chair unless it can be set up with *all* the options the team has recommended for your child.
- Get a full checkout of the chair by a team member before you accept the chair. Be sure you get what you ordered!
- Everyone—including people who use wheelchairs—needs transportation that is reliable, comfortable, efficient, speedy, and easy to use. In order to choose the best chair for your child, learn how *all* the parts of the chair work.

Homemade Equipment for Lying

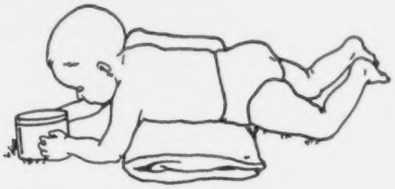
by Barbara E. Clauss, M.Ed., P.T.

You can make or adapt many helpers or aids for your child's special needs and level of development. To make sure the aid is helping—and not holding back—your child, it's important that a specialist regularly evaluate the aids in use.

The first aids your child needs are those that help with lying and sitting. Your pediatric therapist will work with you and your child to find what aids are best for your child. Here are some lying aids that you can buy or make.

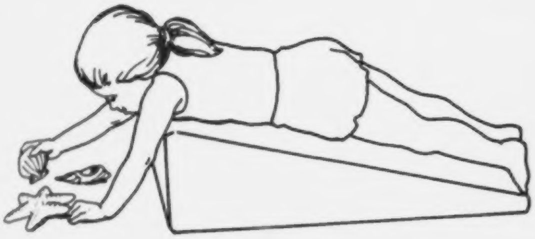
A child first develops control of the head, shoulders, arms, and hands. Stretching the hip, knee, and shoulder muscles is important, too. Children with delayed or abnormal muscular control may need help in these early skills.

A **firm pillow** or small roll under the chest can make lifting the shoulders or raising the head easier. The pillow also helps children who keep their arms back—close to their bodies—because they don't have enough control and balance to reach out. The pillow moves arms forward for reaching out. Make the pillow from a dense piece of foam or simply roll a blanket firmly over a towel.



Use a **wedge** to provide slanted support and to help your child work on head, shoulder, and arm control. Your child's physical or occupational therapist will recommend the wedge best for your child.

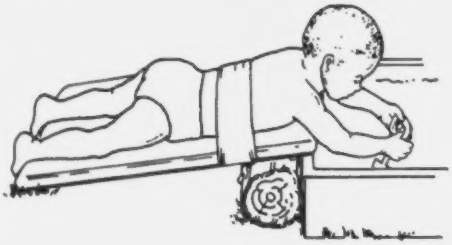
The height of the wedge depends on your child's needs. To help your child bear a little weight on straight arms, the height would be the distance from the child's wrist to armpit.

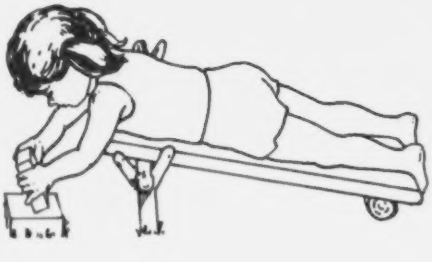


A lower wedge—a little less than the distance from elbow to armpit—lets the child lift up onto the elbows, while a wedge higher than the child's total arm length allows the arms to dangle, encouraging arm and shoulder movement.

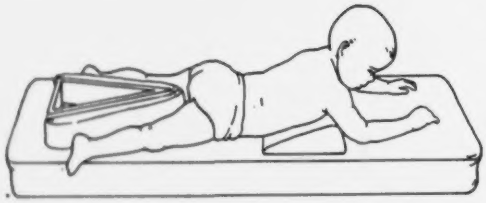
You can make wedges from very stiff foam or plastic, or from layers of cardboard glued together. Look for free scraps of heavy cardboard, called *triwall*, at a local packaging business.

A wedge can simply be a board covered with soft foam. Rest the board on a log or other stable object, or insert a frame made of sticks into the ground. You can easily adjust the support to change the height of the board.



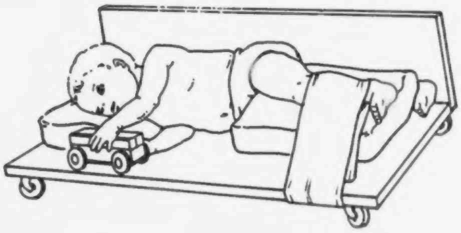


You may need to add a leg separator to a small wedge when your child is in the tummylying position. This position can help prevent and control early *contractures*—when the muscles and joints tighten into positions that interfere with normal movement and positions.



Sidelying frames help some children with severe cerebral palsy control their shoulders, arms, and hands when lying on one side. Use cushions or padded blocks of different shapes to support the head in a straight position and to support the upper leg so it doesn't drop down and put stress on the hip. Use straps only if necessary to keep a good position.

Sidelying frames also help straighten tight hips. Change the child's position from side to side often. Add wheels if you want to move the frame easily.



Make sure to get the advice of your child's physical or occupational therapist before making or using any of these items of adapted therapeutic equipment.

For more information
Finnie, N. 1975. *Handling the young cerebral palsied child at home.* New York: E. P. Dutton.

Werner, D. 1987. *Disabled village children: A guide for health workers, rehabilitation workers, and families.* Palo Alto, CA: Hesperian Foundation.

Homemade Equipment for Sitting

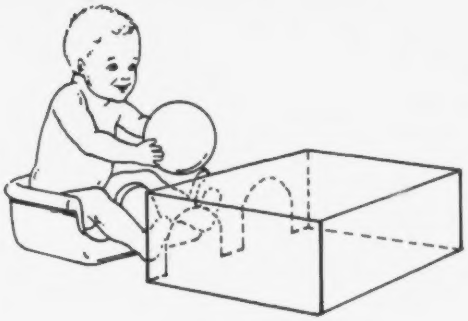
by Barbara E. Clauss, M.Ed., P.T.

Adaptive seating can be a very important part of daily life for a child with physical limitations. Once the child has good seating, you are free for activities that help your child's other developmental needs. The child is upright, so it's easier to look around, and the hands are free for playing and touching. Many children with motor difficulties and developmental delays need the support adapted seating gives.

In order to stimulate *all* the child's senses, the child must be as relaxed and as well positioned as possible. Here are a few of the sitting aids you can build at home for your child.

The box seat

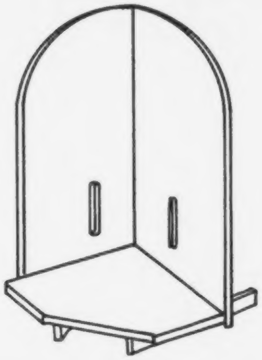
Your child's physical needs determine the child's best sitting position. In one common pattern of muscle tightness, the legs push together and turn in, the shoulders press down, and the arms turn in. Your child's therapist might suggest that you position the child with legs apart and turned outward, shoulders lifted up, and arms turned outward. A simple way to do this is to use a sturdy cardboard box with cutouts for the legs. Use another box, as high as the child's shoulders, as a table.



The box should be narrow enough to support your child's back but still let the bottom be securely seated.

The corner chair

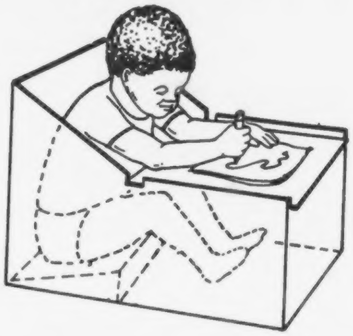
You can make a simple corner chair out of plywood or pressed particle board, a sturdy crate, or triwall cardboard. The angled sides move the shoulders forward and help improve arm and hand function. A separate table or board can attach across the child's lap at mid-chest level. This makes a good surface for playing, which helps develop hand control.



To raise the chair so your child can sit with legs bent and feet flat on the floor, add a wooden base. Be sure to consult your physical or occupational therapist when designing a corner chair.

The adapted box chair with tray

If your child has good head control, you can make an adapted box chair with a tray. Make sure your child doesn't stiffen backwards in the chair. The seat shown here lets the child sit in a relaxed position with straight back and legs forward and slightly bent.

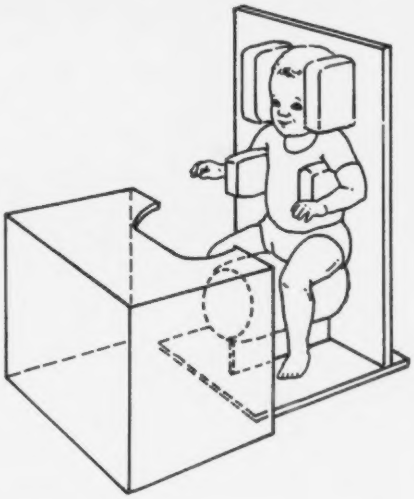


The sloping seat and narrow sides give needed confidence and support to the child who has poor sitting balance. Sometimes extra support or straps are necessary—wedge sandbags or even stuffed toys in on both sides to support the hips better.

The seat angle is very important, because the child's lower back should rest against the support. If the child's arms tend to press down when the child sits, put the tray at mid-chest level and even tilt it slightly. Cut slots in the tray for playtime variety.

The roller chair

A roller chair with saddle seat will help keep your child's legs apart. There are several designs for roller seats, which can be built from plywood or even a log. You can also use a large metal can, depending on how big your child is and how far the legs need to be separated.



Summary

Early childhood skills develop in sequence. Your child starts with head control and then moves on to more advanced levels—reaching and grasping, sitting and balancing, scooting, crawling, standing and walking, and language. Adaptive home equipment for sitting can give your child the support needed for early stimulation, which is vital for mental and physical development.

As in all equipment considerations, consult your child's physical or occupational therapist when you design and build adaptive seating equipment.

For more information

Finnie, N. 1975. *Handling the young cerebral palsied child at home.* New York: E. P. Dutton.

Werner, D. 1987. *Disabled village children: A guide for health workers, rehabilitation workers, and families.* Palo Alto, CA: Hesperian Foundation.

Homemade Equipment for Standing and Mobility

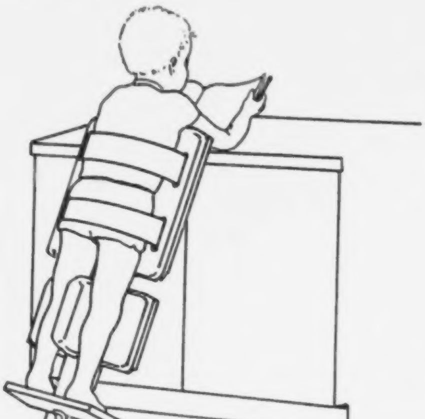
by Barbara E. Clauss, M.Ed., P.T.

Many children with balance problems are unable to stand but can play if they are supported in a standing position. Sometimes children who can't hold their heads up while lying are able to when they are sitting or standing.

Even the child who may never stand or walk without help can be held in a standing position—putting weight on the legs helps circulation and bone growth and strength. Your pediatric physical or occupational therapist will let you know when standing should become a regular part of your child's day.

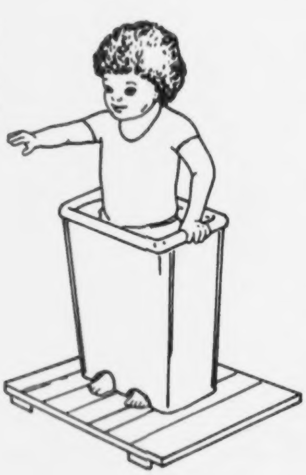
Standing boards or prone standers

A simple standing board or prone stander will hold your child in a standing position when it is propped against a table. The stander can be upright or at an angle, depending on your child's needs.



If extra control is needed, add a knee separator. Depending on how much assistance your child needs, you can add straps at the feet, hips, and upper back.

You can also put your child in a large tile or cement pipe or a plastic garbage container fastened to a wide base.

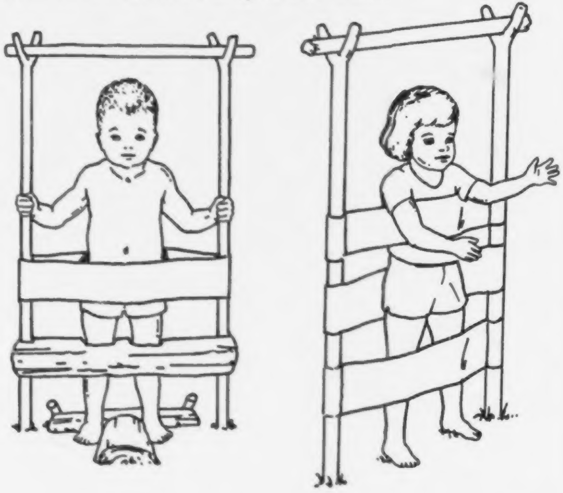


Standing frames

Make a frame of wooden dowels, plastic plumbing pipe, or metal tubing and attach it to a wooden base. Add thick cloths or straps; sew hook-and-loop fastening tape to the ends so you can adjust the straps to fit your child.

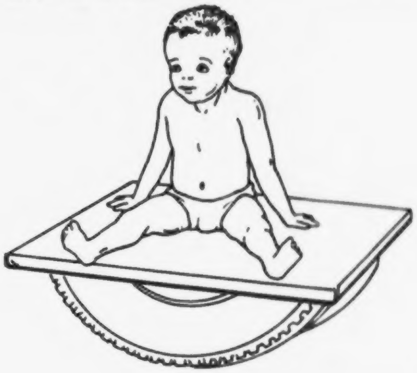
A padded and notched knee board helps keep legs in a good position. Your child is growing; a knee board that is adjustable will be useful longer.

For outdoor use, here are two simple standing frames made of sturdy tree limbs:

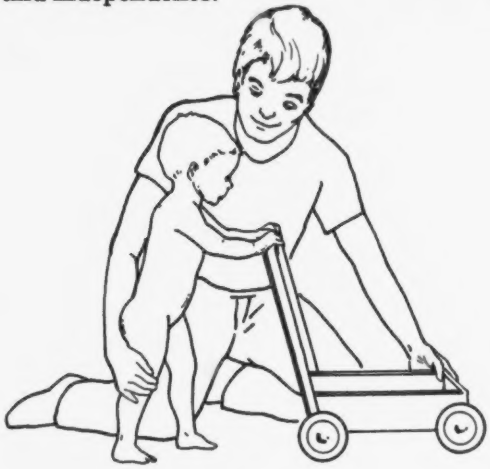


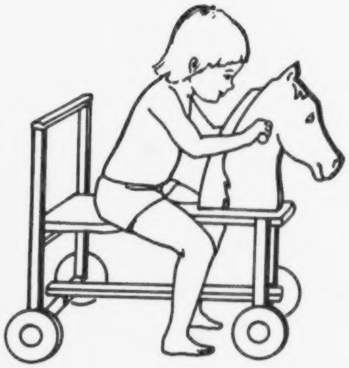
Balance aids and body control

A rocker board can be a fun way to work on balance in both the sitting and hands-and-knees positions. To make a simple balance board, attach a platform to a rocker made of the two halves of a truck tire.



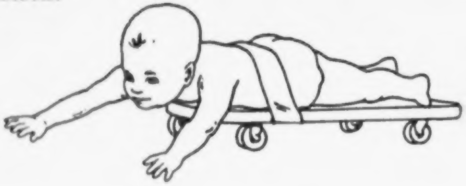
For the child who is beginning to walk or has balance problems, homemade pushcarts or walkers like these can provide both support and independence:



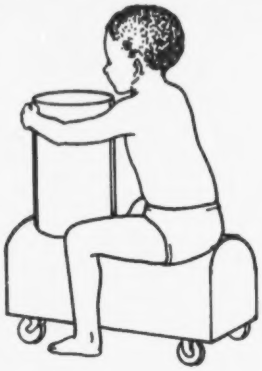


Mobility aids

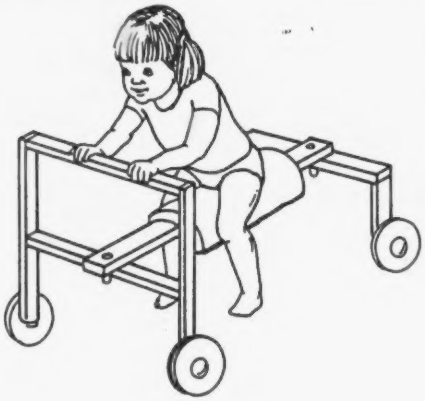
Encourage independent movement with a scooter board—a simple wooden board mounted on four casters. Your child may need only the support of one or more bands around the body to stay on the board and in the correct position.



If your child has good arms and bunny-hops around the floor, a roller seat mounted on casters will let the child use leg pushes to move around. When your child is old enough, switch to a tricycle.



Here is another walker for sitting and standing. Make sure to pad the frame and the rounded seat.



In order to walk, the weight of the body must be forward. This is a problem for many children with cerebral palsy. Infant ring walkers are not adequate walking aids because the child generally uses body stiffness and extension in these walkers and does not learn to shift weight forward.

Simple pushcarts or objects of different heights and weights will encourage your child to push with varying amounts of hip flexion, which leads to walking in a more upright position. Even a simple large wooden box makes a good home walker. The extra stability and resistance makes pushing easier for many children with cerebral palsy.

As with all equipment decisions, make sure to get the advice of your child's physical or occupational therapist before building or using this equipment.

For more information

Finnie, N. 1975. *Handling the young cerebral palsied child at home.* New York: E. P. Dutton.

Werner, D. 1987. *Disabled village children: A guide for health workers, rehabilitation workers, and families.* Palo Alto, CA: Hesperian Foundation.

Mobility Aids

by Barbara Tracy, P.T.

Independent mobility is important for your child's social, emotional, and physical development. Every child needs to explore; special mobility devices can give the support your child needs to crawl, stand, or walk.

A mobility aid can be as simple as an arm-propelled scooter board. Push-wagons and rolling chairs are good supports for the child who is just learning to walk. Tricycles, riding toys, and go-carts can also allow independent mobility.

Your child's tricycle may need special adaptations—footstraps can help keep your child's feet on the pedals; a modified seat can provide trunk support. Hand-propelled tricycles are available if your child's legs are not strong enough to push the pedals.

You can adapt many battery-powered go-carts and riding toys for hand operation. These can help the therapist determine if your child may be able to use an electric wheelchair in the future.

Wheelchairs

Wheelchairs give many children complete independence. There are now many pediatric wheelchairs to choose from. The chairs are more adaptable, too. Because your child may sit in the chair for many hours, it's important that the chair fit well. It should be comfortable and give good support to the head, trunk, and legs. Your child's pediatric therapist will be able to help you choose the best chair for your child.

Some children who use braces or other assistive devices may need a wheelchair only for transportation.

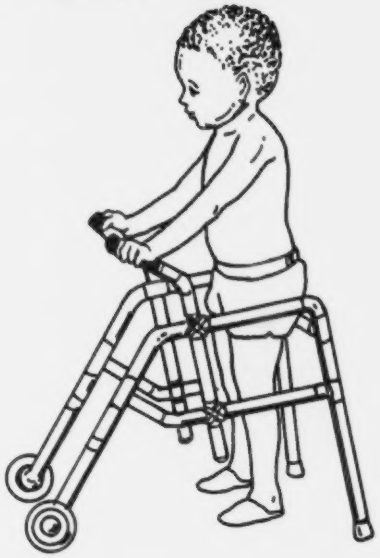
Bracing

To help support the joints, your child may need braces on one or both legs. If the legs are weak or paralyzed, the braces may extend above the knees—sometimes as high as the waist. How and when to brace depends on how strong and functional your child's muscles are. You and your child's doctor, orthotist, and therapist should all join in the decision.

Walkers

Even with bracing, your child may need extra help—usually a walker, crutches, or canes—for trunk balance. Walkers give the most stable support and come with or without front wheels. For a young child, a walker with wheels is usually best, since it requires less energy to use. There is one problem with walkers, though: They are hard to maneuver over uneven surfaces such as gravel, steps, and grass.

With a "reverse walker," the child faces the open side of the walker. Behind the child is a horizontal bar. When the bar touches the child's buttocks, it reminds the child to stand taller and to avoid leaning forward.



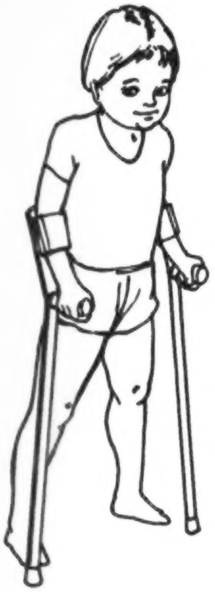
The handles of some walkers are tilted upward or have adjustable grips. These adjustments may be necessary if your child is unable to grasp a regular handle.

Crutches

Crutches can be used on various types of terrain and are easy to maneuver around obstacles, but require greater strength and better balance. Crutches are of two types, *axillary* and *forearm*.

Axillary crutches fit under the armpit. A problem with this type of crutch is that the constant pressure in the armpit may cause nerve damage if the crutches are used over a long period.

Forearm crutches are often easier for a young child to handle, and the cuff around the forearm helps keep the crutch in place.



Canes

Canes are usually straight pieces of wood or metal with a handle on one end and a rubber tip on the other. For more stability, some canes have a wide base of three or four prongs. Even so, canes require better balance than other mobility aids.

Homemade aids

Some children can't successfully use any of the walkers, canes, or crutches on the market. But you may be able to design and build an assistive device that will make walking possible. PVC pipe—available in most hardware and plumbing supply stores—is easy to work with and sturdy enough to support a small child. It can be cut and joined to make a customized walker or crutch. Be sure the bottom end has a rubber tip for safety.

Other commercial aids

If your child lacks the trunk control to use canes, crutches, or walkers, the care team may suggest other commercially available devices that provide maximum trunk support and give the child a chance to move successfully.

Adjustments and maintenance

Equipment that is too tall or too short causes unnecessary stress and may not be safe, so make adjustments as often as necessary to keep up with your growing child. Your child's elbows should be bent at about a 30-degree angle when the child stands erect with hands resting on the handles of the equipment.

Periodic maintenance is very important:

- Tighten all nuts and bolts
- Replace worn rubber tips on walker legs or crutches
- Keep wheelchair tires inflated
- Keep electric wheelchair batteries fully charged.

Choosing assistive equipment

Choosing which mobility aid to use is a difficult but very important decision. Consult with the specialists who know your child and are familiar with many types of equipment.

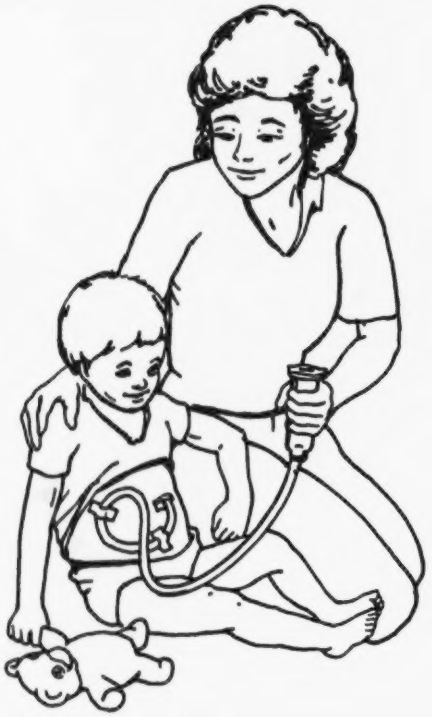
Ask for a trial period before you buy any equipment—sometimes your child will look good using a new piece of equipment but will gradually "sink into" the equipment and no longer achieve the original goal.

Watch your child's needs closely and work toward using equipment that gives *less* support. Children often get stronger and gain more body control as they grow; using the same equipment all the time may not let your child develop and use new muscles.

Your Child's Gastrostomy Tube

by V. Fay Stebbins, R.N.

A gastrostomy tube—also called a *G-tube*—is a soft tube of rubber-like material placed through the skin into the stomach. The tube enters the skin just below the ribs and allows your child to be fed directly into the stomach when swallowing is difficult or impossible.



Why would my child need a G-tube?

There are many reasons your doctor would suggest a G-tube for your child. Usually, several doctors will discuss your child's medical condition with you to decide if a G-tube is necessary.

Reasons for using a G-tube include:

- Difficulty in swallowing
- Poor sucking
- Deformities in the esophagus (tube from the mouth to the stomach)
- Food going into the lungs when the child eats.

Other medical problems can also make using a tube necessary. The reasons are different for every situation and child.

Who puts the G-tube in place?

The first G-tube is placed by a surgeon in the operating room. After the surgery, your child will be watched and cared for in the hospital for a few days. During this time, you will learn how to replace, care for, and feed your child through the G-tube.

What will I need to learn?

Caring for a child with a G-tube is not hard. Here is what you will learn, practice, and review:

- Which formulas and foods to feed through the G-tube
- How to feed with the G-tube
- G-tube feeding schedules
- How to clean around the G-tube
- Signs and symptoms of infection around the G-tube—when to call your doctor
- How to change the G-tube
- Equipment needed for the G-tube and feedings
- Where to get the needed equipment.

Where will I get this information?

Your teachers will be the nurses, doctors, and dieticians at the hospital. Once your child is at home, the doctors and nurses will be your information sources.

Helpful hints

Keep a G-tube supply kit in your auto or with you at all times. The kit should include:

- One G-tube
- Water-soluble lubricant
- Two five-cc syringes

- One roll of tape
- Baby wipes
- Two sixty-cc syringes
- Any other items suggested by your support staff.

Keep a similar kit at your child's school or day-care center. Teach the staff or teachers how to care for your child's G-tube.

You should feel comfortable using and caring for the G-tube before taking your child home from the hospital. Don't be afraid to ask questions, and insist on clear, understandable answers.

Will my child always need a G-tube?

Not necessarily—this decision will be made by your child's doctors. Until the doctor tells you it is time to resume oral feeding, let your child have lots of pleasant mouth experiences. Let your child suck a pacifier, a nipple, or your finger *while* being fed by tube. This way, the child will make a mental link between sucking and getting full—a normal eating experience.

Give your child kisses, and have brothers and sisters and even stuffed toys kiss the child's cheeks. All young children chew on toys—your child can, too. All these normal and pleasant experiences will help keep your child's mouth ready for the time when oral feeding resumes.

Your child's occupational or speech therapist can tell you more about helping your child stay ready for oral feeding. The therapist can also give you pointers when the doctor tells you to resume oral feeding.

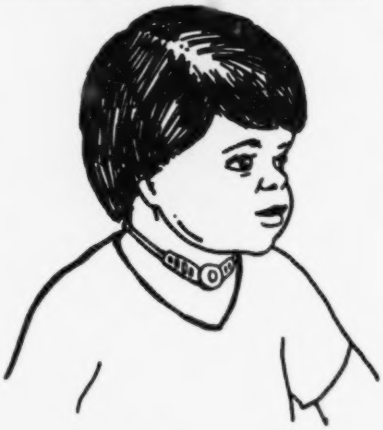
Your Child's Tracheostomy

by V. Fay Stebbins, R.N.

What is a tracheostomy?

A tracheostomy tube—also called a *trach*—is a tube that goes through the front of the throat into the airway. It is usually placed in an emergency, to allow breathing. The person may have medical problems which prevent air from getting to the lungs. Sometimes a machine attached to the trach forces air into the lungs.

A trach will not stop your child from eating, learning to speak, or being held and cuddled. You can care for your child at home.



How to care for your child's trach

The hospital staff will do many procedures for your child. Before your child is discharged, the staff will begin teaching you and other home caretakers how to do these procedures, too.

Each hospital and staff has different methods and equipment, so it is difficult to describe the procedures in detail. But here are the basic procedures and tasks you should learn, practice, and review before you take your child home:

- Cleaning around and under the trach wings
- Changing the trach strings
- Changing the trach
- How often to change the trach
- Cleaning the trach tube
- Which cleaning solutions your doctor prefers
- Suctioning—how to, how deep, and how often.

Your doctor, a nurse, or a medical educator may teach you these procedures. Be sure to practice and understand each of these tasks before taking your child home.

What equipment will I need?

You can get the equipment you need for home care from a home-care supply company, your doctor, or your hospital. You may need:

- Suction machine
- Suction catheters
- Saline squirts
- Extra trach tubes (two the same size as the one in place and one the next size smaller)
- Trach string or substitute
- Cleaning solution for the trach tubes
- Cotton-tip swabs, toothbrush, and pipe cleaners
- Solution for cleaning around the trach and under the wings
- Gloves—sterile and unsterile
- Bulb syringe and/or portable suction mechanism
- Humidifier or cool vapor machine
- Ambu bag (a self-inflating breathing-assist bag)
- Scissors (at least one pair).

Your doctor may recommend other equipment if your child needs aerosols (breathing treatments) or oxygen therapy. Make sure you have all equipment and cleaning materials ready before bringing your child home from the hospital.

Supplies and emergency equipment

- Set up your equipment so you can reach everything easily and quickly.

- Keep a clean trach with the correct amount of string in a clean, sealed plastic bag taped to your child's bed at all times.
- Place the suction machine nearby, with the on/off switch easy to reach. Also have suction catheters and water for clearing the tubing within easy reach.
- If you are given an ambu bag, keep it next to the bed.
- If possible, have a telephone handy for emergencies.

Carry a bag of emergency equipment whenever you are away from home. The kit should be small enough to carry easily. It should include:

- Bulb syringe and portable suction mechanism
- Saline squirts
- Clean trach with string in place
- Tissues and moistened wipes
- Scissors
- Emergency phone numbers for hospital and doctors
- A "HELP" sign for your vehicle.

If your child goes to school, make sure there is an emergency kit in the nurse's office. The kit should travel with your child on public or special transportation.

How closely should I monitor my child?

A person trained to care for the trach must be with your child at all times. **Breathing problems can develop at any time and must be corrected immediately.** Use an intercom system when the child is out of earshot.

What are the warning signs?

- Increased mucus in the airway
- Mucus changes color, odor, or thickness
- Fever or chills
- Increased coughing or gagging
- Increased breathing rate
- Turning blue or gray around the mouth, nose, ears, and/or fingertips
- Flaring nostrils
- Skin pulling in around the bones in the chest area
- Gurgling sound or feeling in the chest or back.

Report any of these symptoms to your doctor. You know your child's normal behavior; changes can sometimes signal problems. Let your doctor be your best friend in keeping your child in good health.

COMMUNICATION

1: Normal Development of Receptive Language

2: Normal Development of Language Precursors

3: Expressive Language Development

4: Normal Development of Respiration for Speech

5: Communication Options for the Physically Disabled Child

6: Effects of Feeding on Speech Development

7: Encouraging Listening Skills

8: The Development of Listening Skills

Normal Development of Receptive Language

by Nancy Williams, M.Sc., CCC-Sp.

What is language?

Language is a system of symbols people use to communicate with each other. It is one way to receive and give information.

Three systems work together to produce language:

- The input system—called *receptive language*—which takes in information through the senses
- The output system—speaking, gesturing, or writing
- The symbol system, which allows the input and output to work together.

What is receptive language?

Receptive language is the input system of language. It is what we see and hear and the information that we take in. Receptive language is the comprehension of information.

Language does not improve according to age alone—it develops as one skill helps the next. Once an early skill develops, it allows more difficult skills to be learned. Language develops in a way similar to physical or movement skills: One stage leads to the next. Receptive language skills begin as early as birth and get stronger with each stage in development.

Normal sequence of receptive language

A newborn baby responds to sound. Loud or sudden sounds startle the baby. Within weeks the baby can tell the difference between happy and angry voices. This is seen when the baby coos in response to a pleasant voice.

Auditory perception—when the baby associates meaning with a sound source—is developing now. At 6 months a baby looks around to find the source of a sound. At 9 months the baby responds to "no." A 1-year-old can follow simple directions.

Here are some points in the sequence of receptive language development:

1 Month	Responds to voice
2 Months	Eyes follow movement
3 Months	Coos in response to pleasant voice
4 Months	Turns head toward source of sound
5 Months	Responds to own name
6 Months	Appears to recognize words like *daddy, bye-bye,* and *mama*
7 Months	Shows interest in sounds of objects
8 Months	Recognizes the names of some common objects
9 Months	Follows simple directions ("Find the ball." "Give me the ball.")
10 Months	Understands *no* and *stop*
11 Months	Appears to understand simple questions ("Where is the ball?")
12 Months	Recognizes names of objects, people, pets, and action verbs
13-18 Months	Understands some new words each week Identifies pictures in a book Identifies a few body parts Identifies some common objects
19-24 Months	Recognizes many common objects and pictures when named Understands possession ("Where's mama's shoe?") Follows many simple directions
25-30 Months	Understands the use of objects Understands prepositions (*in, on, off, out of, up, down*) Understands simple questions Understands pronouns (*I, me, my, mine*)

31-36 Months Listens to simple stories
Follows a two-part direction
Understands taking turns

How can I help my child?

Language stimulation can be fun! You can do language training during your daily routine, but never insist on working if your child resists it. Pick times when your child is eager to work—bath time and story time are natural communication times.

You don't need to reserve a special time for language; each time you stimulate language in a daily activity you help your child learn. The quality of time you spend with your child is more important than the quantity.

Here are some things to try:

Parallel talk: Talk about your child's actions and those of other people. Talk to your child when your child is playing, riding in the car, bathing, or doing any favorite activity. This helps your child learn to connect what the child sees, hears, does, and feels with the words to describe them.

Expansion: When your child speaks or points to an object, be sure to imitate the sound and then give your child the label (the name of the object). For example, if your child points to a dog, give the label, "dog."

Monitor your speaking rate and stress: Talk at a speed your child can understand. You may need to talk more slowly than you usually do. Stress the words you are teaching by saying them louder, longer, or in a high voice. Produce your words clearly without exaggerating them too much.

Expatiation: Enlarge on your child's topic by adding related information to whatever your child is talking about. If your child shows you a dog, talk about what a dog sounds like or eats.

Keep it fun!

Don't ask your child too many questions! Comment on your child's activities, speak clearly, and provide more information. Also, don't make your child imitate all your words. Language stimulation should be fun, not work.

For more information
American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852
(301) 897-5700

Normal Development of Language Precursors

by Jill Heerboth, M.S., CCC

Language precursors are the skills that babies usually acquire before they speak. Language precursors develop from birth to between 18 and 24 months of age. They are divided into three skills: cognition, social/communicative development, and sound production.

Cognition

Cognition refers to thinking skills. For children at a "pre-language" level, thinking skills develop by using and playing with toys and other objects. Here are some important cognitive skills.

Object permanence: This is knowing that something exists even though it's out of sight. When your baby looks down to find a dropped rattle, the baby is beginning to develop object permanence. Soon the baby uncovers a toy that has been hidden under a blanket. In a more advanced stage of object permanence, the baby will look in different places for a desired object.

Means and ends: With this skill, babies are able to use their bodies or other objects to get what they want. When your baby reaches and grasps for your hair, the baby is showing early means/end behaviors. Several months later, the baby may crawl across the room to get a toy. Toddlers climbing on a chair to obtain cookies that are out of reach are showing sophisticated means/ends behaviors.

Cause and effect: By using this skill, babies use objects to create interesting sights and sounds. Babies show early cause/effect behaviors by shaking rattles or squeezing squeeze toys. Other cause/effect behaviors include pushing down on a knob to make a toy operate, dialing a toy telephone to make noise, or pushing away someone's hand to avoid a spoonful of peas. Advanced cause/effect behaviors include winding the handle of a jack-in-the-box to make it work, or turning the knob of a toy radio to produce music.

Object use: This skill involves children's ability to manipulate objects. Babies initially mouth objects as a way to explore them. They then use objects by looking at them, banging them together, dropping them, or throwing them (as in the popular game "Go Fetch"). Eventually, babies will use objects in socially appropriate ways. They will comb their hair with a comb, put on hats, try to put shoes on, or throw a ball back and forth.

Babies have learned a lot about the world once they have some progress in these areas. At that point, they are likely to talk about what they've learned.

Social/communicative development

Children communicate to satisfy wants or needs, to control someone, to establish or maintain social contacts, to express feelings, and to respond to their surroundings. Before they can talk, they communicate with sounds, facial expressions, and gestures. Here are some of the skills—which are present or start to develop at birth—they use to communicate.

Sound: Crying is a newborn's most powerful way to communicate. The early communicative effort of crying is reinforced as babies are fed, picked up, or changed. Infants soon learn to make sounds when someone talks to them, when they see a familiar adult, or when they merely want attention.

As they continue to develop, babies may make sounds when someone takes something away from them, and then eventually to ask for something that is out of reach.

Facial expressions: Eye contact between babies and their caregivers is a very early way to communicate. Smiling, which occurs a few months later, is an important response for developing interaction. Eventually, babies develop facial expressions to indicate when they are happy, sad, angry, hurt, and excited.

Gestures and body movements: From birth, babies move their bodies to communicate when they are upset or to protest when they are being put down. Soon, they may indicate the desire for an activity to continue or happen again. For example, your baby may keep bouncing after you've stopped playing horsey.

As babies learn to control their bodies, their movements become more and more deliberate. They lift their arms to say that they want to be picked up and squirm when they want to be put down. Eventually they learn to point to desired toys that are beyond their reach, shake their heads "no," and hold out an empty cup to indicate they want more to drink. Babies also learn to play games with other people such as peek-a-boo, "So Big," and pat-a-cake.

Children must have a reason to talk or they will not develop language. The use of sounds, facial expressions, body movements, and gestures lays the groundwork for talking.

Sound development

Talking requires very precise coordination of the tongue, lips, teeth, and jaw, along with breathing and vibration of the voice box. This coordination develops as babies develop physical control and are able to experiment with a variety of sounds.

From early on, babies make "ah" sounds if someone talks to them. They soon begin using a variety of sounds. Babies will coo and use vowel sounds (such as *ooh, ah, u* and *ee*), especially if someone picks them up, talks to them, or smiles at them. Babies may even repeat these sounds again after someone has imitated them. They also laugh, yell, and scream. As babies gain more control of their lips, tongue, and teeth, they produce consonants (such as *d, b, m,* and *g*) and then well-defined syllables (such as *ma, da* and *gu*). They will also babble (repeat short, specific sounds such as *ba-ba-ba* over and over).

At 9 to 10 months, some babies may say "momma," "da-da," or specific names. They speak in *jargon*—a combination of consonants with varied inflection which sounds speech-like. They also experiment with an increasing number of different sounds (such as *s, f, z,* or *th*). Generally, they will not use these sounds when they say their first words. Between the ages of 12 to 18 months, babies tend to gradually develop new words. By 19 to 21 months, most babies have a vocabulary of about ten to fifty words.

By 18 to 24 months, children have developed the thinking skills necessary for talking. They can communicate effectively, but want to learn new words to communicate better. Their lips, tongue, and teeth are developed enough for them to experiment with a variety of sounds.

Now they're ready to use these sounds to make specific words. Language precursors are established and talking will develop at a fast rate.

For more information

Lansky, B., and M. Maratsos. 1986. *Baby talk.* Deephaven, MN: Meadowbrook.

Expressive Language Development

by Sharon Hendrickson-Pfeil, M.S., M.A., CCC

You may be wondering if your child is learning to talk "on time" or if your child's speech and language development is delayed. Parents of children with special needs are often concerned about expressive language development, since language delays may be caused or complicated by a wide range of problems.

Some conditions which delay language development are hearing loss, physical disabilities which interfere with learning experiences, problems which directly interfere with speech (such as cleft palate), and overall delays in development and learning.

Most children learn to talk in predictable stages. This is true even for many children whose language development is delayed. You should become familiar with the normal process of speech and language development, so you can better help your child learn to communicate.

Preparing for language

During the first few months of life, babies are already learning to use the senses and the parts of the body which will be necessary for speech. They begin to develop attention, memory, and listening skills. They also learn to control adults by gestures and by different kinds of crying.

Here's how most babies develop the skills that lead up to speech.

During the first month: Vowel-like sounds and crying emerge.

By 2 months: Baby is able to produce different kinds of cries.

By 3 months: Baby begins using *m, p,* and *b,* which are made with the lips and are easy to see and imitate.

Over the next few months, babies begin to use their voices in ways other than crying. They learn to vary their tone of voice to express different feelings, and new sounds start to emerge. Now, the baby begins to stop making sounds while being addressed by an adult. Your child is really listening to you!

By 6 months: May spend long periods of time making sounds. May begin producing simple syllables, such as *ma* and *pa.* This *vocal play* is a very important foundation for spoken language, which will emerge within the next 6 months.

The beginnings of language

The second 6 months are increasingly dedicated to "making things happen." Babies learn how to make the same sounds over and over again. They learn to control adults by using gestures. They learn how to imitate adults' speech sounds. Your baby will show enjoyment while you play together and will begin to take part in simple turn-taking routines such as bath time, mealtime, and simple games such as "peek-a-boo." Gradually, babies put these skills together and learn to use their first real words.

Here are some milestones in this learning process.

By 7 months: Begins to put two syllables together while babbling. Some sounds begin to sound almost like real words. Vocal play is more frequent.

By 9 months: May "sing along" with music and has probably learned to play "peek-a-boo" or "pat-a-cake." Can babble a number of different syllables and is learning to produce new sounds. Asks for toys or food by pointing and making sounds. Shakes head for "no!"

By 10 to 12 months: Tries to imitate new words and usually says first words. More sentence-like sounds are present. May "talk" to family members without using true words. May make sounds as if singing along while listening to music and may wave "bye-bye" when asked to.

By 1 year: The baby who is developing language normally will use from one to three spoken words. However, these words may have uncommon and unexpected meanings—baby may use *bird* for not just birds but also kites and even airplanes!

Developing early conversational skills

During the second year, most children will learn about fifty new words. They are learning to understand simple turn-taking rules and are beginning to really converse with adults.

By 18 months: Toddler repeats some overheard words and usually tries to communicate using real words—not just gestures. May begin getting ready to put phrases together by linking single words with a long pause in between:

"Mommy . . . cookie!"

"Doggie . . . go!"

"All gone . . . milk."

By 2 years: Most children use simple two-word phrases such as *bye-bye daddy* or *more cookie.* Since they have become skillful at joining single words, pauses between words decrease. During this year, the child begins making different kinds of short phrases in order to talk about objects, locations, and actions. The two-year-old will use words to control adults' behavior, to request toys, to answer questions and, of course, to reject some foods or, perhaps, a wet washcloth.

By 2½ years: Children use more short phrases than single words. They usually begin to put together some three- and four-word phrases. At this age, your child will probably sit with you and go through a picture book, repeating names of animals or vehicles and making the appropriate noises. More turn-taking is obvious during conversations.

Mastering language forms

The three-year-old is rapidly mastering grammatical skills.

Children between two and three years old use very simple phrases; they often omit many word endings and small "helping words" (such as *is, are,* and *and*).

In contrast, three-year-olds are rapidly learning to use verb tenses, helping verbs, and other language forms to talk about past experiences as well as about what is going on in the present. They can use many different kinds of words in conversation. At this age, children learn to join short sentences together to make longer ones and begin to use plurals (cars, cook*ies*). They use some basic prepositions (such as *on, off, in,* and *out*) and adjectives (such as *big* and *little*) to describe things.

Language uses are expanding at this age. The three-year-old asks "what," "where," and "who" questions and is able to discuss a single topic over several listener-speaker turns. Many three-year-olds will use language imaginatively while playing with dolls and toy animals.

What do children need in order to develop expressive language skills?

Talk with your child! Children learn to use new words, grammatical forms, and rules for conversation by listening. Teach your child the names of toys, family members, pets, foods, clothing, and places you visit together. Talk about the activities such as playing, cooking, shopping, and household chores that you share with your child. Really listen to whatever your child has to say, rather than asking questions or trying to make your child repeat words after you say them.

What if my child is slow in learning to talk?

See a speech-language pathologist if you think your child is late in developing expressive language skills. This specialist will determine whether there is a problem with your child's language. If help is needed, the speech-language pathologist will recommend an individual program of activities and will provide therapy if appropriate.

Summary

The first three years of life provide the foundation for the development of expressive language. The three-year-old has the ability to participate in conversations and can communicate effectively in simple but complete sentences. Remember, the more you talk with your very young child, the more you help your child learn to talk.

Normal Development of Respiration for Speech

by Nancy Williams, M.Sc., CCC-Sp.

What we call "speech" is a series of sound combinations produced when air from the lungs is forced past and shaped by the jaw, vocal folds, lips, tongue, and teeth.

The flow of air needed for speech is created by inhalation and exhalation. The process is called breathing, or *respiration*. Respiration to produce speech is different from quiet breathing; to know how speech is formed, it's important to know the differences.

Quiet respiration

Quiet breathing draws air into the lungs and removes carbon dioxide. Quiet breathing is easier than breathing for speech, because it takes fewer muscles and less airflow. Quiet inhalation uses the diaphragm and the muscles in the rib cage and between the ribs, which help pull the ribs out and up. This draws air into the lungs.

No muscles are needed to exhale. The ribs go in and down automatically when the muscles relax.

Respiration for speech

Exhalation for speech uses two muscle groups: those of inhalation and those of exhalation. The inhalation muscles help slow down the air flow. The muscles of exhalation help push the extra air that is needed for speaking out of the lungs.

There are three differences between quiet breathing and breathing for speech:

- Breathing for loud or extended speech takes more energy than quiet breathing
- More control is needed for making speech sounds
- Inhaling for speech is faster. Quiet breathing is 40 percent inhalation and 60 percent exhalation; breathing for speech is only 10 percent inhalation and 90 percent exhalation.

Respiration and movement

Physical movement is necessary for respiration to develop normally, because movement helps strengthen the respiratory muscles. When your baby begins to move freely, the baby's breathing becomes more mature—your baby starts to breathe from the chest instead of at the abdomen. This happens when the baby pushes up on the arms.

Respiration develops further when the baby sits, crawls, stands, and walks. Being upright helps the rib cage drop. When the ribs are down the muscles between the ribs stretch and strengthen.

Three things are needed for movement:

- To be in any position other than lying flat on a surface
- Adequate strength of the muscles of the abdomen
- Adequate chest expansion and back strength.

Your baby's respiration will be poor if any of these areas are undeveloped. As your baby becomes more able to sit, crawl, stand, and walk, respiration also improves.

The development of respiration

Here are some important stages of the first year of your child's breathing development.

Newborn to 2 months: Breathing is at the abdomen ("belly breathing"). Baby cannot move out of a flat lying position.

3 to 5 months: Mostly belly breathing. Baby uses arms to push up off the floor. Baby may breathe from chest when in this position.

6 to 8 months: More chest breathing. The muscles of the abdomen are getting stronger. Baby is beginning to sit.

9 to 12 months: The abdominal muscles are stronger and baby is more stable. There is more chest breathing and very little belly breathing. Baby is standing and may be taking steps.

Improving respiration

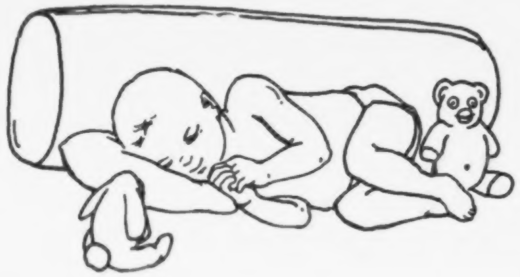
A specialist called a *motor therapist*—a licensed or registered physical or occupational therapist, or a speech-language pathologist certified in neurodevelopmental treatment—can help your child develop the skills and muscles needed for respiration.

The exercises can be carried out by teachers, aides, and parents who have been trained by a motor therapist. Here are some basic things you can do to help improve your baby's respiration. Remember, to develop good breathing skills, your baby needs to *move*.

Stomach activities: Let your baby spend some time in the tummylying position. This puts pressure on the front of the rib cage. To play, the baby can lie flat on the floor or across your lap.

Stretching or lengthening: Put the child in positions where the body is fully stretched. This allows for greater chest and lung movement. Carry the baby in an outstretched position.

The sidelying position: Use pillows to prop your child on one side. Let the baby reach for and play with toys. This puts pressure through the sides of the rib cage.



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Communication Options for the Physically Disabled Child

by Cassandra Faux, M.S., CCC-SLP

Communication options are ways of communicating other than speech. Your very young child communicates with you in a variety of ways—sometimes in ways that are hard for you to see, hear, or understand.

Choice-making, gestures, object or picture boards, and electronic systems and switches can help your child communicate better.

Positioning

Your child's *position* is important—think how often you must move your own body so that you can drive a car, eat a meal, or put on a pair of shoes. In the same way, being in the right position will help your child communicate more effectively.

Positioning someone else correctly can be difficult. Talk to the physical therapist, occupational therapist, or speech-language pathologist. Work together with these people as a team—they can help you decide on the positions that are best for your child.

Choice-making

Choice-making begins with knowing what objects are available in the environment. Your child may not be able to explore or know what is available without your help. When you bring carefully selected objects to your child, you may need to help your child explore the new toy—to see it, to mouth it, and to feel it.

By offering opportunities to make a choice, you help your child learn choice-making skills. Here is an example:

1. Hold a toy where child can see it. Wait until child looks at the toy, and then name the toy as you give it.
2. The next time you show this now familiar toy, also offer a second toy, a new one.
3. Wait for child to look at or gesture toward one of the toys, and then give that toy.

In this example, your child is making—and communicating—a choice. And you are training a communication option—choice-making by looking or touching. Establishing a looking response and a touching or pointing response is important in training a child how to make a *direct selection*. Provide chances throughout the day for your child to make choices—meal time, play time, and dressing time are good moments.

Gestures

Your child may use *gestures* for communication. Gestures could be natural, such as pushing a toy away. They could be done by pantomime, eye blinks for "yes" and "no," or pointing.

Be on the alert! You can establish communication by using the same word each time your child makes the natural gesture. Clapping could mean *more;* a head shake could mean *no.* You may want to physically assist your child with the natural gesture as you say the word the gesture means. Make sure you always praise and encourage the gesture to reinforce it.

Your infant will also learn gestures from songs and games such as pat-a-cake and peek-a-boo. Other examples of using natural gestures with words are *bye-bye, night-night, kiss,* and *so big.*

Using a planned gestural system

Some children with physical disabilities require a planned gestural system in order to communicate. If your child successfully uses a gestural system later in life, it will be because of your efforts when your child was young.

There are several types of gestural systems. Some well-known systems are Early Systems, Sign Language, Educational Sign Systems, and Gestural Language Code. The specialists on your child's care team can help you decide which is best for your child.

Object or picture boards

Making an *object* or *picture board* for your child will help develop both *receptive* (receiving a message) and *expressive* (sending a message) language skills.

The board or boards should show things that you and your child enjoy. You might start by making a mealtime board or a toy board. You can choose a number of different *symbol systems*—systems that use a variety of objects or images with agreed-upon meanings. Objects are usually the first symbols that your child will recognize. Photographs (maybe photos of foods your child eats or of toys your child enjoys) may be the easiest to use on a board.

You may find that your child responds better to line drawings or magazine pictures. Picture stickers are another option. Whatever you decide, you can add to the board(s) or change them as your child grows.

Use no more than four pictures when you introduce a new board. Too many pictures may be confusing at first. More pictures can be added later.

Your child may want to help you design the board by showing you where to place the pictures. Boards can be made out of photo album pages, poster board, cardboard, sheet plastic, or plywood. The boards need to be sturdy—protect the boards from food and drool by laminating them or covering them with clear contact paper. You can do away with the actual board by using magnets or hook-and-loop fastening material and put pictures wherever your child may be likely to see them.

Your child may not be able to point with a finger to pictures on the board but may be able to use a *pointing device,* such as a light pointer, head stick, or adaptive hand pointer. Please consult with the team.

Electronic systems

Your child may not be ready for an *electronic system* yet, but this may be the best communication option in the future. Selecting the right electronic system should be a team decision. Electronic systems can be very expensive, but funding may be available. Make your selection based on your child's needs now and what those needs may be in the future.

The computer as a communication option is also an important educational learning tool. Computers range widely in price; shop around for the computer that best meets your child's needs.

When considering a computer, you will want to look first at the software programs that are available. And you may need to decide if the computer can be adapted so your child can use it. For instance, your child may not be able to press keys on the keyboard.

There are adaptive aids that make the computer useful at all levels of disability, and there are numerous software programs available for all age levels. Today, using a computer is rarely limited by age or physical disability.

Switches

Switches are adaptive devices which can be used to turn on toys, computers, and other electronic communication systems.

A child who cannot use a pointing device or who does not have an accurate "looking response" may be able to activate a switch to indicate a need.

Switches can be custom designed for your child. The team can help you decide on the type of switch and the part of the body that will work best for your child.

Summary

Some people may be concerned that using communication options will delay a child's speech development. Not so! Research has shown that communication options help develop speech and language.

There are many communication options available for you to use with your child. As with any learning experience, practice makes the difference. You may find that *all* of these communication options will help your child, so try to use as many as possible. In any case, it is important that your child learn more than one way to communicate. Members of the team are available to help you.

Effects of Feeding on Speech Development

by Suzanne Evans Morris, Ph.D., CCC-Sp.

Many of the mouth movements used during eating are also used for speech, and feeding problems can help predict future speech problems.

For example, the lips move together and stay closed while removing food from a spoon. The same movement is used for the consonants *m, p,* and *b*.

When we drink, a groove forms down the center of the tongue to help move the liquid from the front to the back of the mouth, and the cheeks tighten and move in toward the gums. This keeps the liquid from leaking out the side of the mouth. These same tongue and cheek movements are needed for sounds such as *f, s,* and *sh*.

How does a child learn and practice the mouth movements used for speech?

When a young baby eats, the tongue moves backward and forward. This movement is used to suck milk from the bottle or breast and to take food off a spoon.

During the first year, the baby gradually learns to move the tongue in an up-down direction. When the baby swallows, the tip of the tongue moves up and touches the roof of the mouth just behind the front teeth. Swallowing happens many times during the day, so the baby learns what it feels like for the front of the tongue to move in this upward or elevated way.

Soon, the baby discovers that it is fun to make noises while eating. Some of these noises happen when the tongue is moving upward. The baby discovers how to make the sounds *d, t, n,* and *l*, which are made with the front of the tongue elevated.

Because a baby eats frequently, there are many chances to practice the mouth movements that will help speech develop. Have you noticed how babies seem to increase sound play and the variety of sounds they make just after they are introduced to lumpy foods and table foods?

Will poor feeding movements cause poor speech?

Feeding and speech movements are similar, but feeding problems don't necessarily cause speech problems. Difficulty in making correct speech sounds has many causes. If a child has problems with sucking, swallowing, biting, or chewing, it may be more difficult for the child to speak clearly.

Children usually use the same kinds of movements for speech that they use during feeding. For example, it is hard for some children to close their mouths well. The jaw pushes open during eating and the lips are rarely closed. These children often use the vowel *ah* when they communicate because *ah* is made with a wide jaw opening. They usually have trouble making vowel sounds such as *ee* or *oo*, which need a very small mouth opening.

Consonants such as *m* and *b* are made by putting the lips together. When the jaw is fully open, the child can't get the lips together, and a word such as *me* may come out as *ah*.

My child feeds well. Will her speech develop normally?

Movement control for speech is much more complicated than movement control for feeding. Many children who eat normally and make most of the sounds needed for speech may make speech errors because they don't have the more skillful control needed to put these movements and sounds together for speech.

The baby who chews and makes lots of sounds will *probably* learn how to use the sounds to talk clearly. Feeding movements and early speech sounds in babbling are like building blocks. You need the blocks to build a house, but the blocks can be put together in many different ways. There's no way to know from looking at a pile of blocks what kind of house a person will build. But, if certain blocks are missing or there aren't enough blocks, it will be hard to build any house.

How can I help my child talk if there are feeding problems?

Find a therapist who works with feeding problems. The most effective programs work with both feeding movements and speech sound movements.

Some children have difficulty putting the mouth movements of feeding together with sound. They may learn to eat with greater skill without changing the way they make sounds. The therapist will help the child make more sounds as mouth skills improve during feeding. This makes it easier for children to make the connections between feeding and speech. Feeding programs should never be silent!

My child has severe problems with speech sounds, but eats meat and other table foods. Should we work on feeding skills?

You and your therapist should look at how well your child eats. Some children with severe speech sound problems can eat table foods, but not without problems. They chew slowly, or swallow unchewed food. They're messy eaters, or they drool with some foods. They may be very picky eaters and refuse many foods.

These children may have very mild feeding difficulties, which can influence their speech sound development. It helps to work on feeding movements with these children, so they have a better physical basis for speech.

How can I help my child?

Arrange for a complete evaluation of your child's feeding and speech abilities. The results of the evaluation will help you know whether a therapy program to improve feeding movements would help your child.

Make funny sounds while eating. This can help your child discover the connections between eating and speech.

Play games with your child to discover how many different sounds you can make with food in your mouth.

If your child is already developing speech, help your child repeat words during a meal. Choose words that have movements that are similar to the feeding movements being used. For example, as you give your child a spoonful of applesauce, ask for the word *more*. If the child's lips are closed around the spoon, it may be easier to close the lips for words beginning with the *m* sound.

Summary

Feeding movements are the building blocks of clear speech. Working to help your child improve mouth movements for feeding will make it easier for your child to learn to speak clearly.

For more information

Morris, S. E., and M. D. Klein. 1987. *Pre-feeding skills: A comprehensive resource for feeding development.* Tucson: Therapy Skill Builders.

Encouraging Listening Skills

by Judith Belk-Kanouse, Ph.D., CCC-SLP, CCC-A

Communication and learning skills grow out of effective listening. Listening is a child's first communication activity; it is essential for learning about and participating in life. Hearing and listening are not the same—listening is an active process of focusing on sound; hearing is passive reception of sound. Listening means focusing on some sounds and "tuning out" others.

Listening has a lot to do with attention span, since it requires the ability and desire to pay close attention to sound. Poor listening can begin at any age and for many reasons, such as a health problem, an accident, a major lifestyle change, or stress. Children with a history of ear infections are particularly prone to hearing and listening problems.

Most of us could learn to listen better. Can you recall a moment when you weren't listened to? Suppose your doctor didn't listen? You know the frustration when you are not listened to. You also know the danger.

What are the effects of poor listening?

Poor listening can lead to major errors or serious accidents. Poor listening during early development may result in problems with attention, memory, speech, language, reading, and other learning and communication skills.

How does listening develop in babies?

Babies with normal hearing can hear during the last few months of pregnancy. The fetus hears sounds of the mother's heartbeat, breathing, digestion, and circulation. The fetus also hears voices—particularly the mother's. Voices occur randomly, compared to the steadiness of body sounds. Music and the sound of the mother's voice interest the fetus. The fetus focuses on these sounds, reducing the effect of other sounds.

This is the beginning of listening. This is the beginning of communication with another human being. When you listened to music during pregnancy, did your baby move more? The developing fetus was becoming attuned—to you and to the world.

A baby born with disabilities may have reduced desire and ability to listen. Many things during childhood influence whether a child tunes in to what is happening. But most children will respond to efforts to rebuild listening skills.

How can I help build my child's listening skills?

The first step is to provide the most comfortable, secure, and loving family life possible. Children who are physically or emotionally uncomfortable tune out threatening sounds. Spend time together listening to soothing music. Some parents play classical music or read children's stories even to newborns. Music and the sound of their parents' voices when reading are soothing to children.

Playing a tape recording of the mother's heartbeat may soothe a fretful infant. Listening to music and a recording of the mother's heartbeat may help the baby deal with the loud sounds of an incubator or respirator.

The rhythm of the mother's bodily sounds, her voice, and her music mean comfort, security, and survival to the developing baby. Think about how rocking and singing reduce distress of young children—this universal effect relates to the comfort and protection of the womb.

The birth cry is your baby's first statement. Your baby learns that you are listening when you respond quickly and eagerly during the early months.

Babies coo, babble, and make jargon sounds while they learn to talk. Respond to these sounds immediately: Let the baby complete a string of sounds and then repeat it. The baby will learn that you are listening and that voices have power. You will also be teaching turn-taking.

Repeat and expand on what your young child says without making an issue of how clear the speech is—the child needs to know that you will listen without criticizing. Praise the sounds the child makes. Stay physically close to the child when talking and listening—this is especially important when the child has a hearing loss.

Be a good role model for listening. Look at the child when you speak and listen. Call the child's name and touch the child's shoulder as you begin to talk to help the child focus on your voice. Avoid interrupting. You're teaching that people have a right to be listened to.

Set aside a **special listening time** each day with the child. Control noise level in the home during this time; turn off the radio, TV, vacuum cleaner, running water, and other noises. Create a special song for the child—make up your own tune or use a well-known melody with your words:

"Big boy, Neil. Mommy and Daddy love you. Today we went to Grandma's . . ."

Sing the song often and invite the child to sing along with you. If possible, move the child's hands, feet, and body in time with the rhythm.

During your special listening time, **speak in rhythms.** Tap on an object near the child or clap your hands:

"Hello, hello, how are you today? My name is Daddy. Here comes Mom . . ."

Encourage other family members to create special listening times with the child. Talk to the child whenever the child is awake. Describe what you hear, see, and touch. If the child eats family foods, describe the taste, aroma, and texture of the food.

Buy tapes or records of children's music, or borrow them from the library. If someone else cares for your child during the day, make a video or audio tape recording of you and other family members saying or singing something personal for the child. Have the caregiver play the tape several times a day. Are there special songs in your family to sing to children? Would Grandma or Grandpa record these songs?

Reading and telling stories are essential to speech, language, and listening development. Make up short stories at the child's interest level. Look through magazines or catalogues and point out interesting items. Cut out pictures to create a "listening book," adding new pictures every day. Include family photos. Ask the child to find specific details in the pictures (such as a dog, a big dog, a big black dog, a dog and a cat, actions, and colors). Name items for the child to find in one room, then expand to two items in one room and then to one item in one room and a second item in another room.

Grocery shopping is a wonderful time to point out categories of items and objects. The produce department is filled with colors, smells, textures, shapes, and sounds. Shopping can help your child learn to listen carefully to know what is coming next ("Now let's find soup").

Bathing, changing clothes, feeding, riding in the car or bus, and many other daily events are also good listening times.

Summary

Remember the three basics of encouraging listening skills:

- Set a comfortable scene to invite and support listening
- Be a good listener yourself
- Provide sounds which children find interesting—especially music and voices of people dear to them.

If you need help teaching your child listening skills, consult a speech-language pathologist or audiologist.

For more information

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Katsh, S., and C. Merle-Fishman. 1985. *The music within you.* New York: Simon and Schuster.

Verny, T. 1981. *The secret life of the unborn child.* New York: Dell.

The Development of Imitation Skills

by Rebecca D. Yeatts, M.S., CCC-Sp.

What is imitation?

Imitation is the ability to copy the actions, sounds, words, or facial expressions of another person. The ability to imitate appears very early in life and is refined for many years.

Imitation involves paying attention to something another person is doing or saying, then trying and gradually learning to copy the action, sound, or words accurately.

Your child may imitate you as soon as you do something (such as when you say "bye bye" and wave and the child begins to wave, too). Or the imitation may be delayed—it could be the next day when the child puts on a coat and goes to the door and remembers to wave when someone says "bye bye."

Why are imitation skills important?

Children learn to use language by imitating the people around them. Imitation also helps us learn the customs, accepted gestures, and body language of our culture, and how to interact with other people.

Development of imitation skills

Imitation skills develop in steps. One step builds on the one before it, until the child no longer imitates but uses skills spontaneously. Here are the average ages of children when they show some of the significant points in the development of imitation skills.

At a few months of age: Babies first learn to imitate eye contact and to pay attention. They take turns in interactions with their parents; they smile, frown, and use other facial expressions. Most babies become very good imitators by simply watching and copying the people around them.

7 to 8 months: Babies learn to make many different sounds and begin to imitate the sounds of others. The sounds the baby made earlier were entertaining and automatic, rather than in imitation. Usually, babies imitate sounds that they can see, such as "ma," "ba," and "pa," and funny sounds, such as tongue clicks, lip pops, coughing, "raspberries," and animal noises. Hearing problems are often discovered at this point, because it is harder for a child who does not hear well to imitate sounds.

12 months: Children begin to imitate intonation; sometimes they sound like they are using words and sentences. When you drop something and say "uh oh," your child may copy your gestures and say "uh oh." Children at this age pretend to talk on the telephone, scold their toys, or comment on something that has gone wrong. They are also excellent imitators of "pat-a-cake," "peek-a-boo," and other finger plays and songs.

Most parents of babies are very good at talking in single words or short phrases. They use lots of gestures and facial expressions and maintain eye contact with their baby naturally, making it easy for the baby to learn to imitate. As the child grows older, parents usually automatically adjust their words and phrases, gestures, and facial expressions to the child's level.

Before the first year, and continuing for several years, children learn to play with toys and other children by imitating and experimenting. Parents unconsciously teach babies to play by showing them how to shake rattles, work "busy boxes," push pop-up toys, wind musical toys, and look at books. Later, children learn to imitate complicated games, household routines, and habits.

After age 1: Children become better imitators and begin to imitate actions and words. At first, the imitation may be inaccurate (such as "gog" for "dog"). The child will learn to imitate sounds more precisely as control of the muscles and coordination needed to use speech sounds increase.

At about 18 months of age, children take great pleasure in watching and copying the same songs and finger plays over and over.

At 18-24 months, children use a variety of words to express themselves and begin imitating the combination of words into two- and three-word phrases. When mommy leaves the house and someone says "Bye, mommy," the 18- to 24-month-old will probably be able to imitate without any trouble. At this stage, parents tend to talk in two- and three-word phrases, so imitation is easy. The child's sounds may be inaccurate, but the child can imitate longer combinations of words.

After age 2

Children continue to imitate words, longer sentences, more precise sounds, and household routines, and more complex songs, dances, and finger plays. Gradually they take on more of the mannerisms and way of speaking and interacting of those around them. Imitation continues to be refined even into adulthood.

Do imitation skills need to be taught?

Most babies imitate, remember, and learn naturally, but children with disabilities may need help. The child who is hearing impaired or who doesn't learn as fast as other children may need to be taught sign language and will take longer to learn to imitate speech. The child who is visually impaired needs to learn to imitate through touch and hearing, rather than sight. The child with a physical disability may not have enough muscular control to imitate accurately.

Children with disabilities may need to be learn alternate ways of communicating (such as with pictures or computers), but they learn to use these devices by imitating other people.

How can I help my baby develop imitation skills?

Talk face-to-face with your baby from about 12 inches away. This helps the child see your face clearly and watch your facial expressions and eye contact. To hold your baby's interest, change your pitch from high to low and your loudness from whispering to normal voice. Alternate between funny sounds and speech sounds.

Don't be afraid to look silly and have fun! Babies like funny faces and funny noises and can become bored more easily than we think. Hold your baby in front of a mirror and encourage a conversation with the "baby" in the mirror.

Encourage older children to talk to and play with your baby. Young children love to imitate other children and often copy their expressions and sounds more easily than those of an adult.

When your baby makes a sound or face, imitate it. Turn-taking can go on for a long time and will help your baby learn that communicating is fun.

Children who are between the developmental ages of 1 and 2 can learn to imitate sounds by making animal noises along with the animal words. Other fun sound-making activities include making motor noises with cars, trucks, and airplanes, and commenting on actions with sounds (such as "pat pat" and "tickle tickle").

Young children also learn imitation skills through copying finger plays and games (such as "Itsy Bitsy Spider," "The wheels on the bus," "so big," "pat-a-cake," and "peek-a-boo"). Dancing and clapping with music is another way.

Children begin to recognize themselves in the mirror around 18 months of age, but mirrors will interest them earlier. This is a good time to teach the imitation of sign language, identification of body parts and clothing, and the imitation of sounds and words and funny faces. Use puppets and other toys to keep it interesting.

When teaching the imitation of words, phrases, or sentences, make sure to use language that is not too long or complicated. If the child uses only the first sound of a word—such as "b" for "book"—then say back the word "book." If the child says "book," then add another word, such as "want book." Language is easiest to imitate when it is expanded in small pieces.

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VISION

1: Normal Visual Development
2: Testing Your Child's Vision
3: Encouraging Movement in the Visually Impaired Infant
4: Encouraging Language Development in the Visually Impaired Child
5: Toys and Experiences for Your Visually Impaired Child

Normal Visual Development

by Irene Topor, M.Ed.

Vision is one of your baby's most important ways to learn about the world. The first three years of life is a critical time for your baby to be visually alert and learning about objects, people, and events.

Your baby sees some things from the moment of birth, because much of the visual system has already developed. Vision develops in a predictable way; here's what happens before and after birth. The ages are averages; every baby is a little different.

Before birth

- 16 weeks fetal age: Eye movements occur.
- 25 weeks fetal age: The light-sensitive cells in the eye can be seen.
- 28 weeks fetal age: The muscles that control the pupils have developed.
- 32 weeks fetal age: The *cornea*—covering the lens—appears. The *optic nerves*—the visual pathways that connect the eyes and the brain—are in place.

Your baby is able to visually learn about the world, but the visual systems are not fully developed. Here are some of the changes that should occur in your baby's visual behavior during the first three years.

At birth

- The cornea becomes fully transparent.
- Can tell colors apart, but the ability is not mature for all colors until 2 to 3 months.
- Until about 3 months, sees things to the side better than to the front.

Your baby's ability to notice details and differences quickly increases, but attention to different nearby areas may be limited. The ability to shift attention rapidly increases during the first 2 months.

3 months

- The shape of the cornea makes close objects a little out of focus. Sees best at a distance of eight to ten inches.
- The way the pupil reacts to light continues to develop.
- Begins to recognize your face. At first, baby scans the angles, shapes, and outline of the face. By 3 months, scans the eyes and mouth, unless there is an unusual feature—such as glasses, glitter, or paint—added to the face.

4 months

- Sees detail and color. Probably knows your face from a stranger's and prefers yours.
- Can *accommodate*—shift focus from one distance to another—from eight to thirty inches away and *converge*—turn the eyes inward—with good precision to look at a target at close range.
- *Binocular* vision—the ability to focus both eyes on one object and see one image—is fairly well developed and is closely linked to accommodation and convergence. Should respond to horizontal and vertical lines, and black-and-white checkerboard and bull's eye patterns.

6 months

- Watches everything that is nearby.
- At a slightly earlier age, baby gazed at hands, batted and swiped at hanging objects, and tried to grasp objects. Now baby stretches both arms out to grasp an interesting-looking object or to touch your face. This shows that some depth perception—the ability to see the three-dimensional relationship between objects—is developing.
- Reaching skills continue to develop until 12 months. Baby watches the activities of others, looks at pictures in books, and dumps and fills containers.

12 to 18 months

- Practices visual-motor skills: Scribbles, builds a tower with cubes, attempts to imitate strokes, places a circle in a one-piece puzzle and pegs into a pegboard.

- Is interested in simple picture books and in touching bold colors.

2 years
- Sees detail in pictures.
- Works on matching things that are the same and different.
- Matches objects to pictures.
- Recognizes detail in pictures.
- Becomes aware of upside down and right side up.
- Continues to draw and place square and triangle shapes in puzzles.

3 years
- Matches and sorts by color and shape.
- Matches objects to pictures that are not identical.
- May be able to sort pictures of common objects and draw a person with a head and one or two other features.

Many of these "visual behaviors" involve the use of eyes and hands together. During the first three years, eye and hand development cannot be separated.

How can I help?

Here are some things you can do to help your baby learn to use eyes and hands together.

From birth to 8 weeks, help your baby practice focusing by keeping your face or another interesting object eight to ten inches away. Later, hang a small textured ball about ten inches above the baby's face. Your baby will practice reaching out to swipe over and over again.

By 6 months, use cradle gyms and other objects to encourage your baby to reach out and grasp. The more your baby looks at, swipes at, bats, reaches for—and grasps—toys, the better the chances are that eye/hand skills will be strong in later years. This will help in building towers with blocks, putting together puzzles, drawing, and other activities.

Summary

Every person is unique, but vision develops in a predictable sequence. The eye develops physically before birth; after birth, vision continues to develop. Your child will learn to use both eyes together and to distinguish lines, shapes, and objects. Soon your child will begin to touch and grasp everything in sight.

Hand and eye development are closely linked during the first three years. By the toys you give and the kind of play you encourage, you can help your child's vision develop normally.

For more information
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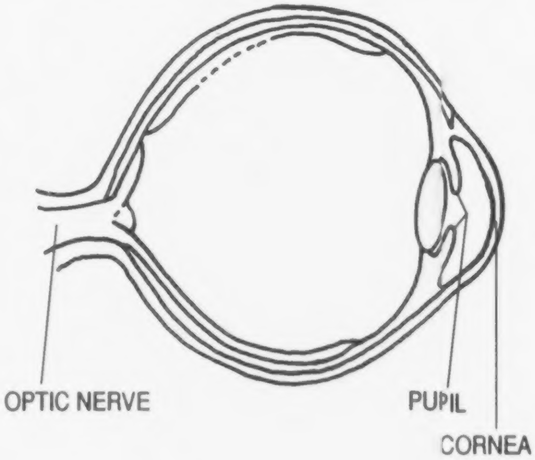


89

Testing Your Child's Vision

by Irene Topor, M.Ed.

What is a functional vision assessment?

A functional vision assessment measures how well your child uses vision under different conditions. It can also show how you can stimulate your child's use of vision. The assessment is given by a *vision specialist*—a professional trained to measure how children use vision.

Who should have a functional vision assessment?

Any child with a medically diagnosed visual impairment should have an assessment. A *pediatric ophthalmologist* or *optometrist* can determine if your child needs an assessment.

Visual function is based on the child's experiences and desire to see, as well as the condition of the eyes, so function may be different for each child—even if the visual impairments are the same. Two children who can see hand movements may each use color, light, and shape differently.

Children with multiple disabilities often have vision problems. If your child has other disabilities, have an eye doctor check your child's vision. If an eye problem or disease is identified, your child should visit a vision specialist.

Tell the doctor if your child takes any medications. This is important because medications can affect your child's visual functioning and sensitivity to bright lights.

What can the functional vision assessment tell about my child?

Your child's ability to use vision may not be related to your child's *visual acuity*—how clearly the child sees detail—or medically diagnosed visual impairment. The eye doctor's evaluation, together with a functional vision assessment, will determine how your child sees best.

Here is what the vision specialist will check to determine how your child best uses vision:

Positioning. Some children with multiple impairments see better when they lie on their backs or sides. Others do well sitting in a chair by a table, or on the floor. Your child will always see better when the head is supported and steady.

Vision development. The specialist may use a checklist to see how your child's visual development compares with that of other children.

Lighting. The specialist will determine if your child prefers lighting that is incandescent or fluorescent, and bright, average, or dim.

Using both eyes together. The specialist will check your child's ability to use both eyes together. This important ability helps your child judge near and far distance.

Size and color of objects. The specialist will watch your child play with many different interesting-looking toys to see if some colors and sizes are more effective than others.

Near and far distance acuity. Using special picture cards, the specialist will test your child's ability to see detail. Your child will look at the pictures at 16 inches and then at 10 feet.

The Teller Acuity Test measures the visual acuity of infants and toddlers. Your child will look at stripes on cards and show a preference for certain cards. The specialist will test each of your child's eyes separately and then together.

Visual field/visual field preference. Some children see better to one side or the other, or below or above eye level. Your child may prefer one visual field, or might not see at all in some visual fields.

Tracking, scanning, and shifting attention. To check your child's ability to visually follow nearby and distant moving objects, the specialist will watch how your child's eyes move from one toy or person to another. Your child might need more time to look at people, objects, and events.

Using vision to get around. Your child may use vision to crawl and walk. The assessment will determine if your child needs help in using vision to move about familiar and unfamiliar places.

Recognition/discrimination/visual perception skills. Two- and 3-year-olds can do visual tasks such as match colors or geometric forms. They can color, cut and paste, match letters and words, and read words on sight. The specialist may test your child on some of these skills.

How can I help my child use vision?

Remember: Vision is a learned process. Your child needs time and practice to use vision efficiently.

Review the results of your child's eye exam and functional vision assessment. Request copies of both reports. Be sure you understand your child's visual impairment. Ask the vision specialist how the assessment can help you help your child.

Use natural, daily activities to help your child use vision. Provide the recommended special lighting, toys, and colors during play, feeding, dressing, and social times. Use other techniques—such as positioning the child and presenting objects in certain visual fields—at the same time.

Encourage your child to use vision. Say: "Look at the dog," or, "See the car!" Praise your child's attempts to use vision.

Watch how your child looks at things. It may seem as though your child is not looking at an object, but this may be how your child *needs* to look to see.

Some children need to touch and look at objects to learn. Let your child do this at first, if the vision specialist approves. Gradually encourage your child to just look, if appropriate.

The way your child sees may vary; tiredness and medications both affect visual functioning.

Tell your eye doctor and vision specialist about new skills and any changes. Discuss with the specialist any task for which you think your child can learn to use vision.

Summary

A functional vision assessment determines how your child visually functions in daily activities and under specific conditions. It will help you and your child's teachers know which activities will help your child see best while playing, eating, enjoying a social occasion, and learning.

Work with your eye doctor and vision specialist to create an environment that will help your child learn to see as well as possible.

Encouraging Movement in the Visually Impaired Infant

by Marsha Dunn Klein, M.Ed., O.T.R.

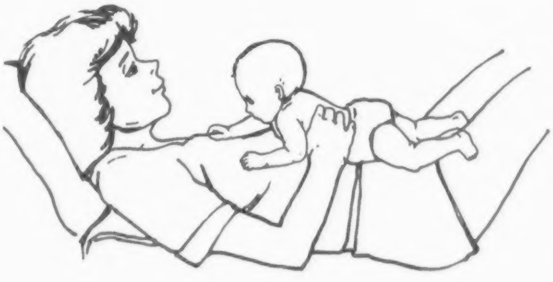
Your visually impaired infant *will* learn to move but needs your help to develop the confidence to reach out. There are many things you can do at home to encourage your child to move.

Encourage tummylying

Your infant may prefer backlying (the *supine* position) to tummylying (*prone*). Backlying is more comfortable, and less work. A sighted child will enjoy looking at the ever-changing world while tummylying, but your child doesn't have sight as a reason for head-lifting and may be happy keeping the head down.

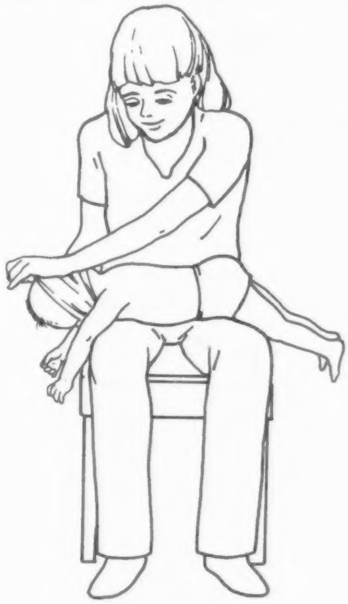
Many movement skills develop from the tummylying position; you need to help your infant enjoy playing in this position. Here are some activities to try.

Use your body as a surface for your baby to lie on. From this position your baby feels your body, hears you speak, and can head-lift in response to your play. The child can feel your breath on the face and have fun without realizing this is the tummylying position.



Place your baby on the crib or the floor in a tummylying position. If your baby is already backlying, slowly roll the baby over. Keep noisy toys handy to encourage play in this position.

Sing songs with your baby tummylying on your lap. Use this position in dressing—such as when taking off pants or pajamas.



In all these positions, your child practices lifting the head and learns to enjoy tummylying. The baby prepares for reaching and rolling from the tummylying position. To encourage head-lifting, routinely carry your baby in the tummylying position.

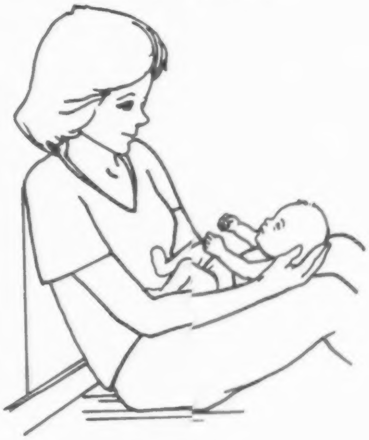
Arms forward

During early infancy, most babies rest in a somewhat curled or flexed position. They practice moving in and out of this position by reaching and kicking.

Visually impaired babies who are premature have spent less time curled in the womb and are often less flexed at birth. They often lie flatter and have more difficulty lifting their arms and feet. It's important to give your new baby chances to curl the body, bringing the arms forward and the feet up.

To help bring arms forward:

- Carry your baby in a curled position
- Position the baby on your lap with arms forward for exploring
- Encourage your baby to reach toward your face—talk to the baby, or even blow on or "nibble" the baby's fingers.



Weight shifting

Visually impaired infants often prefer to stay in one position rather than risking moving into and out of positions—it's safer to stay close to the center of the body than to reach out to the unknown.

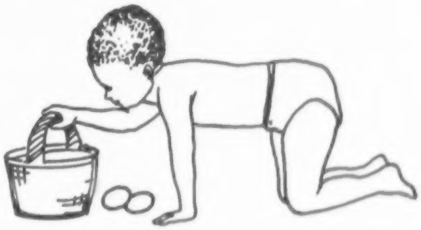
They tend to stay on their tummies or backs and stay in a sitting position when placed there. Often, they play with toys close to their bodies. Your infant needs to have reasons to reach out from the body and to shift weight from side to side. This weight shifting will allow more mobility and independence.

You can help your child gain the confidence to move in and out of different positions. Give your child noisy toys to reach for from tummylying, backlying, sitting, all fours, and standing. Encourage forward, sideways, and diagonal reaching.

At first, your child may reach only an arm's length, but with confidence and practice, reaching can lead to complete shifts in body weight.

Your child will start putting weight on one arm while reaching from a tummylying position, or shifting weight from sitting. Soon your child will be on all fours.

Offer noisy toys to encourage reaching in the all-fours position. That helps your child learn to weight-shift as a preparation for creeping.



Stepping out

Weight shifting from a standing position helps set the foundation for stepping. These small weight shifts build confidence for walking along furniture, following walls, and, finally, for independent stepping.

Play games to encourage weight shift to the front, rear, side, and diagonally so your child becomes confident with all types of movement.

Your baby needs a safe environment

Your visually impaired infant needs a safe and encouraging environment. Movements such as reaching from sitting, rolling, creeping, or walking can be scary when the obstacles can't be seen.

At first, keep rooms the same so your child knows where the furniture is. Spend time together, so your child will feel confident reaching for toys and furniture. Keep experiences positive and fun, so your child will be willing to take the risks needed to learn independence. Be patient; it takes time, but you and your child will learn together.

For more information
Move With Me, available from:
Blind Children's Center
4126 Marathon Street
P.O. Box 29159
Los Angeles, CA 90029

Encouraging Language Development in the Visually Impaired Child

by Nancy Williams, M.Sc., CCC-Sp.

The degree to which visual impairment affects a child's language development varies. Many children with partial vision develop language at a normal rate; others have difficulty with some or all stages of language development. Because each visual impairment is unique, it's important to know how your child sees the environment.

What should I know about my child's vision?

You need to know *what* and *how* your child sees. If your child has total loss of vision, it's vital that you stimulate activities through the other senses. If your child has partial vision, it's important to know the distance, color, and size of objects that best help the child to see. Your child's vision specialist can help you understand your child's visual abilities.

What are prelanguage skills?

Your child must develop these other skills before learning to communicate well with speech or gestures:

Sensori-motor skills. These are your child's physical skills. They are developed in play and strengthen your child's understanding of how to play, explore, and relate to the surroundings.

Social-communicative skills. We use important social skills when we communicate. We pay attention to other people, and we take turns when we talk and listen. Turn-taking is important for your child and is often learned in imitation games. Your child needs to be able to start a conversation or activity as well as join one started by someone else.

Be aware of your child's attempts to communicate with you. Watch the child's hands for signs that the child needs or wants you. Listen for any sounds that may be requesting your attention. Be aware of the child's movements—they may be attempts to gain your attention or respond to you.

Your child may use hands but not facial expressions to express needs or wants. Try not to always assume your child's wants, but let the child try to express them to you.

Receptive language. This is the information we take in or comprehend. Even an infant receives information, by listening to the tone of a voice or watching facial expressions. Not being able to see what is being talked about can make it difficult for your child to understand, so it's very important that you give your child as much information as you can.

Your child needs to use all the other senses to help make up for the loss of vision. Help your child learn the sound, touch, movement, taste, or smell of an object or activity. Put your infant in a tummy pack or carry your toddler with you. Your child will begin to associate a gust of cold air with the refrigerator as well as the sound of the door opening, ice cubes, milk being poured, and meat drawers opening. The dryer will be associated with a buzzer, the opening of a door, warm clothes, and the scent of fabric softener.

Talk about the things you do together, since your child cannot see them. Say the names of objects, and describe your movements and your child's. Describe things; talk about the dew on the "wet" swing and how it moves "fast" or "slow" as you push your child. Tell your child what you are doing: "I push swing." "I lift you up." Don't always ask questions; make statements, too. It's easy to take vision for granted; it's important to share experiences with your child.

What is expressive language?

We use *expressive* language—speech, gestures, or sounds—to communicate wants, needs, and thoughts.

Visually impaired infants often use hand movements instead of expressions or eye gazes in their early attempts to communicate. When older, they'll use their hands to express many of their wants and needs. As a parent, you need to be aware of this.

Talk about everything you're doing and look for chances to match words to your child's sounds or gestures. Use words that your child might use in that setting. If your child turns toward where the last bite of food came from and begins to squeal, say "more food" as you give another bite. If your child reaches out and touches your hair, say "hair" or "mommy's hair." Don't assume your child understands or can use a word until you use it many times and in a variety of situations.

Some language characteristics of the visually impaired child

Echolalia. The child imitates what you say but does not carry through or show any understanding. An example is when you ask your child: "Do you want your blocks or your doll?" and the child answers: "Your blocks or your doll?"

Echolalia usually occurs when a child does not understand. Being able to touch the item may make the message clearer.If your child echoes you, repeat the question and let the child touch both toys. Wait to see if the child makes a choice, either verbally or by reaching.

Pronoun confusion. Many visually impaired children confuse the use of pronouns such as *I, you, he,* and *her.* Often, they use proper nouns instead of *I.* The child may say "You want a cookie" to request a cookie—perhaps because that's how the child hears the pronoun used.

Often, when speaking to a visually impaired child, people use only proper nouns to refer to others. For example, the mother tells her son: "Katie wants an apple. Give it to Katie." It would be better to say: "Katie wants an apple. Give it to her." Make sure to use "I"—say "I want more," rather than "Mommy wants more."

Spatial relations. Sometimes visually impaired children need help to learn how the locations of things are related. This often comes from not having a good idea of where their own bodies are in space.

You need to give information about where things are located in a given activity:

> "Your shoes are *behind* you."
>
> "Sit *next to* the boy."
>
> "Put your hands *over* your head."

Your child can't see these actions, so physically guide the child through the movement while you repeat the statement.

Inappropriate topic. At times, your child may say something that has nothing to do with immediate context. This may be a way to gain your attention, or because the child is not paying attention to what's happening.

First, make sure your child's statement does not relate to the present activity. Then guide your child back to the appropriate topic. If the child persists, ignore the inappropriate speech and keep trying to draw the child into the present activity or conversation.

How do I use this information?

Try to make the suggestions part of your daily routine. Remember that language develops best in a natural activity and with repeated experience. For more help, your pediatrician can refer you to a speech pathologist and vision specialist.

For more information
American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852

American Brotherhood for the Blind
Twin Vision Lending Library
18440 Oxnard Street
Tarzana, CA 91356

American Council of the Blind
Rt. A, Box 78
Franklin, LA 70538

American Printing House for the Blind
1839 Frankfort Avenue
P.O. Box 6085
Louisville, KY 40206-0085

National Federation of the Blind
Box 552
Jefferson City, MO 65102

Toys and Experiences for Your Visually Impaired Child

by Kelly Marts, Certified Vision Teacher

Your child's most important toys and experiences come from you. Loving your child and providing a secure play area are the most important things your family can do to help your child learn about the world. There are many things you can do to make your child's sensory world richer and increase your child's learning and fun.

Here are some things you can do to help your child explore:

- Move your child through actions and talk about them at the same time.
- Sit behind your child as you demonstrate a movement. At first, put your hands over the child's hands and move them together.
- Show your child how to handle each new toy. As your child learns the skill, give less and less help.
- Listen to your child. Describe objects and answer questions, but avoid asking questions.

Do things with your child at times when the event would naturally happen. For example, teach your child to put on socks when dressing or before going outside to play. Listen and give answers to questions rather than asking questions. Your child will be growing quickly; it helps to write down when new abilities appear in a notebook or baby book. Another way to keep track is to use a developmental list as a checklist.

Here are some ways to stimulate your child's senses.

Hearing: Let your child know when you're nearby by saying your name and touching the child each time you want to make contact. With an infant, you might shake a noisemaker, ring a bell, whistle, or hum. At first, touch your infant's cheek to make sure the head is turned toward you.

Encourage your baby to listen while you run your finger across a comb and use appliances, and as your baby slaps a hand on a new surface. Other good noisemakers are pie tins, pan lids, spoons, and paper towel tubes. Talk with your baby about the new sounds, and encourage your baby to copy the sounds you make, such as *da-da, lo-lo,* and *gee-gee.*

Smell: Expose your baby to a variety of smells—such as cedar, vanilla, flowers, pine, mentholated salve, and cooking extracts—by putting the smells in clothes drawers or on the sheets in the crib. Try giving each room its own smell.

Touch: Use touch to give your child as much information as possible. Fill a box with different kinds of cloth, such as velvet, silk, and terry. Describe the different textures.

You might also use the laundry basket, or set aside family clothes for your baby to play with. Don't ask whose sock your child is holding; instead, describe the sock ("It's long, soft, black, and ribbed.") Then identify the owner of the sock.

A box of paper also makes a good toy. Your baby can tear, crinkle, and throw the magazines, phone book, wrapping paper, and cellophane. **Caution:** Some inks are toxic, so make sure your baby doesn't eat the paper.

Turn bath time into a learning time by adding a sponge, a spoon, a strainer, ice, warm water, or a cup. With your help, your baby could use some of the same toys in a tub full of textures—try beans, foam packing "peanuts," macaroni, and cloth pieces.

Motion: Dance while holding your baby. Hold your baby high in the air; at the same time, say or sing a song about being very high.

Tie a string to a toy or rattle; your baby might enjoy pulling the object by the string.

Things to play with

Shopping for toys can be difficult—it's hard to know if your child will like a particular toy. Before buying a certain toy, try to borrow one first, or locate a toy library. Look also for a store with sample toys for your child to try.

The play materials listed below will let you change toys often without spending a lot of money. Describe each new toy—your child needs to learn about many different objects. Your child can explore tastes, smells, sounds, and feels by matching, sorting, comparing, pouring, stacking, and nesting.

Here are some objects to use:

Plastic bowls
Lids
Potholders
Baking cups
Empty boxes (cereal, bandage, oatmeal)
Cups (measuring, drinking)
Egg cartons
Milk jugs and cartons
Paper plates
Mesh bags (onion, potato, and fruit)
Yarn
Tape
Paint roller
Sponges
Feather duster
Plastic jars
Measuring spoons
Socks
Blankets
Unbreakable mirrors
Empty thread spools
Old keys

Supervise your child's play for safety reasons and because learning is much more valuable when you talk with your child during play.

Concepts

Emphasize these basic concepts as your child plays:

In/out
Up/down
Top/bottom
Left/right
Front/middle/back
Dry/wet
Dark/light
Fat/thin
Long/short
Shallow/deep
Large/small

A child with a visual impairment cannot see the relationships behind these concepts. Show the relationships first with your child's body, then between your child and an object, and finally between two objects. Be patient; it will take time for your child to understand.

Encourage other family members to play with the child in the same way you do. Show other family members and the babysitter how it helps to sit behind the child and work hand-over-hand at first. Remind them to listen to the child and to give answers but avoid asking questions.

An older child needs to learn more about where things go and what they do. Let the child help put away groceries, toys, small tools, and laundry. Daily tasks are another way to encourage learning. Use the hand-over-hand method to show how to pour milk, where the foods come from to fix a sandwich, and what different soaps smell like.

Try to find other ways to make your child's sensory world richer. Most of all, enjoy helping your child to play safely and learn at the same time.

For more information

Leach, P. 1977. *Your baby and child: From birth to age five.* New York: Alfred A. Knopf.

Moore, L. 1985. *Beginnings: A practical guide for parents and teachers of visually impaired babies.* Louisville, KY: American Printing House for the Blind.

HEARING

1: Normal Auditory Development

2: Hearing and Hearing Loss

3: Your Child's Hearing Aid

4: Childhood Ear Infections

5: Teaching Language to Your Hearing-Impaired Child

6: Communicating with the Hearing-Impaired Child: The Aural-Oral Approach

7: Total Communication with the Hearing-Impaired Child

Normal Auditory Development

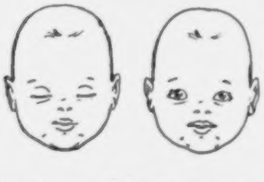
by Ellen Goldman, M.S., CCC-A

What is normal auditory development? Hearing or *auditory* behaviors grow and change along with your baby's other skills—as your baby matures, you'll see different kinds of responses to sound. The development of eye and motor coordination is closely linked to the development of auditory skills. If motor skills are lagging, your baby's auditory development will also be delayed.

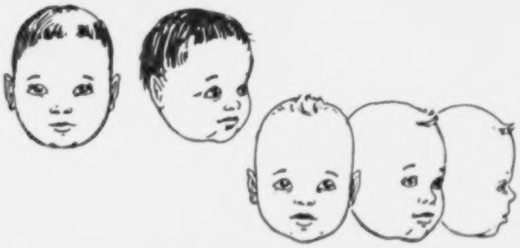
What behaviors are usual for babies with normal hearing?

The information below tells how babies use their hearing as they grow. If your baby doesn't have good head control, or is lagging in development, you may not see the response to sound expected for your baby's age. Keep in mind your baby's *developmental age*—your baby's functional age, according to the level of developmental skills—when you use this guide.

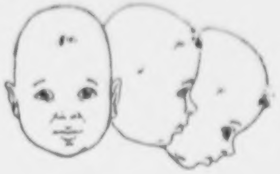
Newborn: startle reflex. From birth to 4 weeks, baby will jump or startle to a sudden, loud sound. Eyes may widen or blink, and arms and legs may fling out. A sleeping baby may move or begin to waken. Your voice will soothe and comfort your newborn.



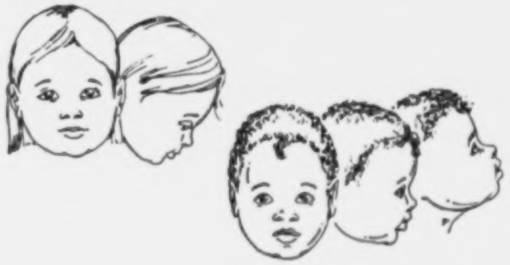
3-6 months: searching response. Baby will turn eyes and head to look for an interesting sound, or when you call baby's name. Should enjoy music and noise-making toys. Begins to coo and gurgle, and to repeat sounds (such as *ooh, aah,* and *ba-ba*).



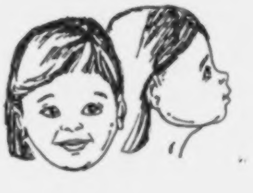
6-10 months: localization. Baby will look up or turn toward an interesting sound or toward you when you call baby's name. Will respond to familiar voices and familiar sounds such as the telephone ringing or dog barking. Should make many different babbling sounds, even when alone. Understands common words such as *no* and *bye-bye*.



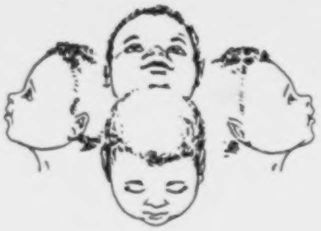
10-15 months: responds to speech. Before starting to talk, baby spends many months learning to understand when you say simple things. Plays with own voice—enjoying the sound and feel of it—while learning to make the sounds used in talking. Should imitate simple words and sounds, and may use a few single words meaningfully.



15-18 months: direct localization. Can directly *localize*—identify the source of—all sounds. By 1½ years, a baby who hears normally should respond correctly to simple speech by pointing to body parts and following other simple directions. Should use three or four words in addition to *ma-ma* and *da-da*.



24 months. A 2-year-old with normal hearing has the foundation for speech and language development. Your child should be well on the way to talking and understanding speech.



When should I have my baby's hearing tested?

To learn to talk and to understand speech, your baby must be able to hear. If you think that your baby has a hearing problem, talk to your doctor and have the baby's hearing tested by a pediatric audiologist right away. **A baby is never too young to have a hearing test.** When a hearing loss is found early enough, many things can be done to help your baby.

How can I help my baby learn to listen and talk?

- Talk to your baby pleasantly and naturally.
- Hold your young baby close to you and talk or sing quietly.
- Try to imitate the sounds your baby makes.
- Provide noisy toys—rattles, squeakers, and bells.
- Play word games and laughing and tickling games with your baby ("Pat-a-Cake," "Peek-a-Boo").
- Read books and talk about objects and toys. Ask your older baby to point to the pictures.
- Call attention to sounds around your baby, and noises made by toys.
- Make simple speech sounds and animal sounds, and encourage your baby to imitate you.
- Name objects such as toys, foods, and body parts, and encourage your baby to imitate the words.
- Sing simple songs, say simple, short rhymes, and play musical games with your baby.

Helping organizations

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852
Helpline: (800) 638-8255

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612
(312) 243-8400

Alexander Graham Bell Association for the Deaf
3417 Volta Place, N.W.
Washington, D.C. 20007
(202) 337-5220

American Society for Deaf Children
814 Thayer Avenue
Silver Spring, MD 20910
(301) 585-5400

For more information

Simmons-Martin, A. 1975. *Chats with Johnny's parents.* Washington, DC: The Alexander Graham Bell Association for the Deaf.

100

Hearing and Hearing Loss

by Ellen Goldman, M.S., CCC-A

How does the ear work?

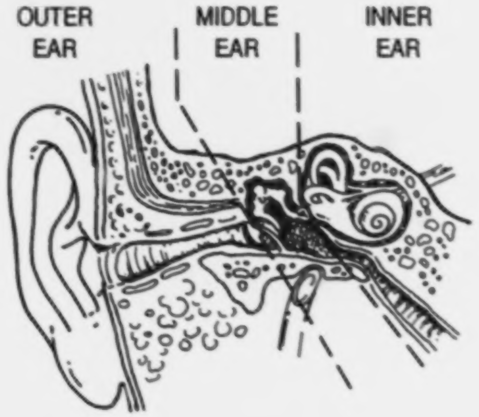
There are four main parts of the hearing system:

Outer ear. Includes the part of the ear on the outside of the head and the ear canal. The outer ear collects and funnels sound waves to the eardrum.

Middle ear. Begins at the eardrum. The eardrum is connected to three tiny bones, called ossicles. They are linked in a chain so that they connect the eardrum to the inner ear. The Eustachian tube goes from the middle ear to the throat and keeps the pressure in the middle ear the same as the pressure outside the ear.

Inner ear. Contains the balance system, the cochlea, and the auditory nerve. The cochlea is filled with fluid and lined with thousands of tiny nerve cells which convert sound vibrations into nerve signals.

Central auditory system. Consists of the nerves which carry the nerve signals to the brain, which makes sense of what is heard.



Sound waves are collected in the outer ear and moved down the ear canal to the eardrum. The eardrum vibrates; the vibrations pass along the chain of bones in the middle ear to the fluid in the inner ear. The vibrating fluid moves the nerve cells, which convert the vibrations into nerve signals and then pass the message to the auditory nerve and up to the brain.

Are there different kinds of hearing loss?

Yes. There are three types of hearing loss: *conductive, sensori-neural,* and *mixed.*

Conductive hearing loss. A conductive hearing loss is caused by a problem in the outer or middle ear. It is called "conductive" because something blocks the movement—or conduction—of sound into the ear. Some causes are:

- Excessive wax in the ear canal.
- A hole in the eardrum.
- A broken ossicle.
- A middle ear infection. This is the most common cause of a conductive hearing loss. The infection causes fluid to build up in the middle ear, slowing down the transmission of sound.

Sometimes a baby is born with an incompletely formed ear. Part of the outer ear may be absent or misshapen, or the ear canal may be very narrow or completely closed.

Most conductive hearing losses are medically or surgically treatable. But when a baby is born with a malformed ear, surgery cannot always correct the problem. In those cases, a hearing aid can help the baby to hear better.

Sensori-neural hearing loss. A sensori-neural hearing loss is caused by a problem in the inner ear or the auditory nerve. When damage occurs to the cochlea, sound may be distorted; the amount of hearing loss depends on the extent and location of damage. Some things that damage the nerve cells in the cochlea are:

Maternal diseases—such as German measles (rubella), venereal disease, or other viral infections—during pregnancy. Some of these diseases can be passed on to the baby through the uterus or from the mother after birth.

Rh factor. The mother's and baby's blood can be incompatible.

Drugs. Some medications may injure or destroy the nerve cells in the cochlea. Also, drug and alcohol abuse during pregnancy can harm the baby's hearing system.

Stressful delivery. Sometimes the baby cannot breathe during the stress of prolonged delivery. The cochlea is very sensitive to the lack of oxygen around the time of birth, and the nerve cells can be damaged or destroyed.

Low birth weight. A baby who weighs less than 1500 grams (3.3 pounds) at birth is at high risk for a hearing loss. A premature baby often has immature lungs, which causes breathing problems and increases the chance of hearing loss.

Hyperbilirubinemia. This blood condition can cause a hearing loss, especially when it makes a transfusion necessary.

Heredity. The genes for hearing loss can be passed on to the baby.

Genetic syndromes. Sometimes a baby is born with a group of problems that is called a syndrome. Hearing loss can be associated with certain syndromes.

Approximately one baby in 800 is born with a sensori-neural hearing loss, because of problems during pregnancy or delivery, or genetic (inherited) conditions. Sensori-neural hearing loss can also result from problems that occur after birth.

Postnatal causes of hearing loss. Infections such as mumps, measles, and spinal meningitis can cause hearing loss. Other causes include head or ear injury, high fevers, and some medications.

The cause of almost half of all sensori-neural hearing losses is not known. Sometimes whatever causes the damage to the cochlea or auditory nerve also affects the balance mechanism. When this occurs, your baby's movement skills may be delayed.

Sensori-neural hearing losses are permanent, but hearing aids help most children to hear better. Some children are being helped with cochlear implants—surgically implanted devices which stimulate the auditory nerve.

Mixed hearing loss. A mixed hearing loss is when a child has both a conductive and a sensori-neural hearing loss. Some syndromes cause the outer and inner ear to be malformed, which can cause both types of hearing loss. Also, if a child with a sensori-neural hearing loss gets a middle ear infection, the two types of loss combine to create a greater hearing loss.

Central auditory deficit

Some babies have problems—such as bleeding or a blood clot in the brain, a tumor, or meningitis—in the brainstem or the auditory nerve. Sound travels through the ear with no problem but cannot be processed in the brain. A central auditory deficit or auditory processing problem is less obvious than other hearing problems, but it may affect a child's ability to learn language.

What do I do if I think my child has a hearing loss?

Talk to your doctor about having the child tested by an audiologist. Don't delay—even newborns can be tested.

Undetected and untreated hearing loss can cause problems with your child's speech and language development. A child learns to talk by first listening. Birth to age 2 is when your child begins to develop speech, and good hearing is needed to develop speech and language skills. The earlier your child's hearing loss is treated, the better.

Helping organizations
National Information Center of Deafness
Gallaudet University
800 Florida Avenue, NE
Washington, DC 20002

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852
Helpline: (800) 638-8255

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612
(312) 243-8400

For more information
Simmons-Martin, A. 1975. *Chats with Johnny's parents.* Washington, DC: The Alexander Graham Bell Association for the Deaf.

102

Your Child's Hearing Aid

by Ellen Goldman, M.S., CCC-A

How does a hearing aid work?

A hearing aid picks up sound and amplifies it—makes it louder. The hearing aid amplifies all sounds, not just speech.

All hearing aids have three basic parts: a *microphone,* to pick up sound and change it into electrical signals; an *amplifier,* to make the signals stronger; and a *receiver,* to change the signals back into louder sound waves.

What your child hears through the hearing aid sounds different from what you hear. The aid makes sound louder but not clearer. The aid may not pick up some pitches of sound, and it may distort some sounds.

What kind of hearing aid is best for my child?

The kind of hearing aid the audiologist will recommend for your child depends on the amount of hearing loss. It's hard to measure the exact amount of hearing loss in a very young child—eye-blinks, head-turns, and other clues help determine what your child is hearing.

The audiologist may lend your child an aid before making a final selection. You can also provide important information about what sounds your child responds to at home, and about any problems your child has with the aid.

How can I help my child adjust to the hearing aid?

Some children adapt very quickly to wearing a hearing aid. Others take more time. Your child will need time before being able to wear the aid for long periods. Wearing an aid needs to be a part of the daily routine, like getting dressed in the morning.

At first, put the aid on your child for short periods in a quiet place. Be firm; if your child objects to the aid or pulls it out, put it back in. Or put the aid away and try again when the child is in a more cooperative mood. Gradually increase the wearing time until your child wears the aid all day.

Talk to the audiologist if your child constantly removes the aid. The earmold may be irritating the ear, or sounds may be too loud. Sometimes taking the aid out is a way to get attention.

Your attitude is important. Be patient; don't be discouraged if your child doesn't immediately accept the hearing aid. Associate the aid with happy situations.

How can I help my child learn to listen?

- Talk to your child. Your child is a normal child who happens to have difficulty hearing. You are introducing your child to the world of sound. Help your child understand the meaning of sound—talk about what you're doing and what's going on around you. Encourage your child to look at your face when you talk.
- Hold your baby, and sing and talk in a normal voice. Repeat sounds your baby makes.
- Call your child's attention to sounds in your home: "Listen, I hear the washing machine." Introduce your child to household sounds such as the ringing telephone, the doorbell, the vacuum cleaner, and running water.
- Go for a "listening" walk outside. Listen to traffic noises, barking dogs, sirens, and other things.
- Look at picture books together. Play simple games such as "Pat-a-Cake" and "Peek-a-Boo."
- Have fun and play with your child. Teaching listening skills doesn't have to be a chore.

How do I know my child is hearing?

Your child may show little awareness of sounds when first beginning to wear hearing aids. What your child hears also depends on the amount of hearing loss. It may take several months of listening experience before you see many responses.

Some ways your child may respond to sound are:

- Smiling or frowning
- Blinking or opening eyes widely
- Stopping an activity such as sucking, moving, crying
- Looking up or searching after a sound occurs
- Crying after a very loud sound or noise
- Pointing to ear, or touching the hearing aid

Your child may not respond every time a sound occurs. You can help by following the suggestions outlined above and by calling attention to sounds and voices. Direct your child to the sound by saying "Listen! I hear something." Point to your ear and use facial expressions to show your interest. Keep the hearing aid on your child and make listening an ongoing activity.

When will my child start talking?

A newborn with normal hearing spends about a year listening before saying even one word. A child who has just started to wear a hearing aid needs the same amount of listening time.

Your child's "hearing" age starts from the time the hearing aid is first used. As with the newborn, your child must learn to listen and to use sound. Your child must wear the aid regularly in order to make sense out of sound.

How do I care for my child's hearing aid?

Your child's hearing aid must work properly. Check the aid every morning. Here are some items to help you care for your child's aid:

Battery tester. Check the batteries every night and replace weak batteries. Always keep spares at home and at your child's school or day-care center.

Listening stethoscope or tube. Connects to the hearing aid and makes it easy for you to listen to it and make sure it is working.

Hearing aid dehumidifier. Removes moisture and perspiration from the hearing aid, earmold, and tubing. The aid and earmold are kept overnight in a closed container with a chemical that prevents damage to the aid from excessive moisture.

Forced-air earmold cleaner. Removes moisture and obstructions from the earmold and tubing.

Pipe cleaners. Use to dry and clean the earmold.

How can I keep my child's hearing aid in place?

Double-sided tape. Put a small piece of tape on the back of the aid to hold it in place. Tape used to hold hairpieces in place works well.

Fishing line. To make sure the hearing aid doesn't get lost if it falls out or is pulled out, tie a piece of fishing line to the earhook where it attaches to the aid. Then attach the line to a safety pin at the back of your child's collar.

Huggie Aids™. These are commercially available hearing aid retainers. A circular piece of tubing fits around the ear and attaches to the aid with straps. The straps can go over the battery case and volume control to prevent your child from playing with them.

Why are properly fitting earmolds important?

The earmold must fit properly in your child's ear. If a mold is too small, sound leaks out from around it. This causes the hearing aid to "whistle" because of feedback. Your child needs a new earmold if the aid whistles often. Do not turn the loudness setting down to stop the whistle; your child will not be hearing all sounds properly.

Expect to buy earmolds often. A baby grows very fast and may need new molds every two to three months. If a new mold doesn't fit properly, have another one made—there's no reason to accept a poorly fitting earmold. For the aid to work properly, your child must have good earmolds.

For more information

Simmons-Martin, A. 1975. *Chats with Johnny's parents.* Washington, DC: The Alexander Graham Bell Association for the Deaf.

National Information Center on Deafness
Gallaudet University
800 Florida Avenue, NE
Washington, DC 20002

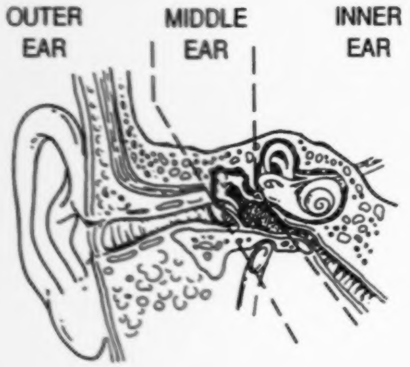
Huggie Aids™ is a trademark of Huggie Aids, 837 NW 10th St., Oklahoma City, OK 73106.

Childhood Ear Infections

by Melinda M. Heald, M.S., CCC-A

What is an ear infection?

When people talk about ear infections, they usually mean *middle* ear infections, or *otitis media*. The infection is behind the eardrum in the middle ear space.



The infection can cause fluid to collect in the middle ear, and a hearing loss develops. In most cases, your child will run a fever, be fussy, and may pull on the ears at the beginning of an infection. Sometimes, infections are "silent"—your child may not appear to be ill at all.

Who gets ear infections?

Ear infections are the most common illness that doctors treat in children under age 5. Nearly every child has at least one ear infection; the average child has four to six ear infections by age 3. A few children are "otitis prone" and have more ear infections than average, because of frequent illnesses, birth defects (such as cleft palate), or syndromes (such as Down syndrome).

Why do children get ear infections?

It can be very hard to pinpoint the exact cause of your child's ear infections. Here are a few of the many causes:

- Family history of ear infections
- Contact with children who are sick
- Birth defects such as cleft palate
- Smoking in the home
- Allergies
- Climate
- Bottle propping

Regardless of the causes for the ear infections, the normal function of the *Eustachian tube* is usually affected. The Eustachian tube is the passageway from the middle ear to the back of the throat. When the tube is blocked, air can't pass into the middle ear and fluid cannot drain out.

Why be concerned about ear infections?

Hearing loss. Any infection should be taken seriously. Ear infections cause extra concern because they *might* result in a hearing loss in your child. The amount of loss varies and usually clears up once the fluid behind the eardrum is gone.

To get an idea of how speech sounds to a child with an ear infection, plug your ears with your fingers and listen to someone talk. Sounds have a remote, underwater quality. With a middle ear full of fluid, the sounds your child hears are muffled and unclear. You may find yourself talking in a loud voice so your child can hear you clearly. This is because sounds have to be louder than normal to get from the eardrum through the fluid and to the hearing nerve.

Speech and language problems. Children with ear infections are more likely to have speech and language problems. Ear infections occur most frequently between birth and age 3, which is also the critical period for children to learn speech and language. It's important to clear up an ear infection as soon as possible, because hearing loss caused by frequent ear infections can interfere with normal speech and language development.

What will the doctor do about my child's ear infections?

To get information about your child's medical history, the doctor will ask you questions such as:

- How does your child behave when there is an ear infection?

- How many ear infections has your child had?
- How have the ear infections been treated in the past?
- Do you think your child has a hearing loss?
- Do you think your child's speech and language is normal or delayed?

The doctor will examine your child to see if there is an ear infection. Using a special light—called an *otoscope*—the doctor can see your child's eardrums to diagnose whether there is an infection or fluid present in your child's middle ears.

The doctor may prescribe medication to clear an infection. But if the infections and hearing loss continue, the doctor may refer your child to specialists for other treatments. Your child may see:

- A doctor who specializes in treating the ear, nose and throat—an *ENT* or *otolaryngologist*.
- An *audiologist* who is trained to test children's hearing.
- A *speech-language pathologist*, to evaluate your child's speech and language development.

Other methods of treating ear infections include long-term use of antibiotics and the insertion of ventilation tubes through your child's eardrums.

How can I help?

Understand the nature of ear infections.

- An ear infection is just one of many things that will happen in your child's life. Most children have ear infections, and few ear infections are dangerous.
- Your child may outgrow ear infections.
- There is little you can do to prevent ear infections.
- Discuss the information in this article with the doctor.

Observe your child's behavior. Every child with an ear infection acts differently. Does your child's behavior signal an ear infection or something else?

Watch your child for signs of hearing loss.

- Does your voice calm your crying child?
- Does your child ask "what?" or "huh?" frequently?
- Do you have to raise your voice to talk to your child?

Understand your child's treatment before you leave the doctor's office. Ask the doctor to clarify anything you don't understand. Make sure you know how to give your child the medications the doctor prescribes. And be sure to give your child *all* of the prescribed medication.

Ask your child's doctor:

- What can I do at home to relieve my child's ear pain?
- Should my child ride on an airplane when there is an ear infection?
- What is happening with my child?
- How is it being treated?
- Why was a certain type of treatment chosen?
- When do I need to bring my child back to the doctor?
- Who else needs to be involved in my child's treatment?

Have your child's doctor send reports to any specialists your child sees. And have the specialists' reports sent to the child's primary doctor.

Encourage your child. Ear infections can be annoying and frustrating for both of you.

Play with your child and read stories to stimulate your child's speech and language development. If your child has a hearing loss, hold the child close to you or talk loudly so that your child can hear better.

For more information

Grundfast, K., and C. Carney. 1987. *Ear infections in your child: The comprehensive parental guide to causes and treatments.* Hollywood, FL: Compact Books.

Teaching Language to Your Hearing-Impaired Child

by Joni M. Kiser, M.Ed.

Your child has just been diagnosed as having a hearing loss. There is much you need to learn about the nature of your child's hearing loss and the resources available to help your child.

Right now you have many questions: How do I purchase hearing aids for my child? What community resources are available? What family support programs are available? What intervention program and what preschool program is best for my child?

An early decision you will need to make is what communication approach to use with your child. It's an important decision, and it will affect your family life and your child's life for a long time. Explore the options carefully before you decide.

In the meantime, it's important that you continue talking to your child, playing, developing good eye contact, and making sure the child can see everything that goes on nearby. If your child has a hearing aid, work to increase hearing aid wearing time, as prescribed by your audiologist. But remember: Your child is just that, a child—someone who needs to laugh and play, love and be loved, and be an integral part of family life.

Why is early treatment so important?

Early communication with hearing-impaired children is vital, because there is a critical time for learning language. During the time from birth to age 5, your child learns:

- Speech and language
- The values of your home and culture
- To share feelings, ideas, and love.

Hearing is a very important part of learning language. Usually, the language delay will be more severe the later the hearing loss is identified, and the greater will be the need for intensive intervention. Without amplification and language intervention, the child struggles to make meaning of the spoken word. Reading and writing can be more difficult, too.

What communication choices are available?

Families are the most important partners in the education of their children. One big decision you will need to make is which communication approach to use with your child. Some of your choices are:

The **auditory-oral** approach. This trains your child to make the most of the child's speech and hearing abilities. May or may not involve using a hearing aid.

A **total communication** approach. This uses different combinations of speech, hearing, vision, speechreading ("lipreading"), signing, fingerspelling, reading, and writing.

American Sign Language and other visual communication systems.

No one approach is best for all children; each approach has strong merits for different children and different families. Parents often switch approaches several times before making a final decision. Often, children help decide.

Hearing-impairment specialists are divided over which approach is best for acquiring speech and language. Keep that in mind when interviewing therapists and learning about your options for educating your child. Contact the different parent organizations, speak to parents in your community, visit different programs, speak to hearing-impaired individuals, and listen to your child.

Which approach is best for my child?

Here are some questions to help you decide on your child's treatment.

- How old was the child when the hearing loss was identified?

- How do you and your family now communicate with the child?
- Are you willing to work daily and commit a great deal of time to the auditory-oral approach to help your child learn to speak, listen, and speechread?
- Are you willing to attend sign language classes and use all available means to communicate?
- What resources are available in your area? Who can help identify the services available?
- How much residual hearing does your child have?
- Is your child beginning to use hearing in a meaningful way?
- Are you willing to make sure your child wears the hearing aid all day, every day? Without it, most children with a hearing loss will not acquire speech.

Where can I find help?

Federal law requires every state to set up a comprehensive system to identify and help children (and their families) with hearing problems and other special needs. Every state department of education has a Child Find system.

Some other sources of support are:

University-affiliated speech and hearing departments

Audiologists

Speech and hearing professionals and teachers of hearing impaired children.

Here are several organizations that help families of children with hearing impairments. The organizations have different philosophies; ask questions, evaluate, and find out what works for *your* family and *your* child.

The Alexander Graham Bell Association
3417 Volta Place N.W.
Washington, DC 20007

American Society for Deaf Children
814 Thayer Avenue
Silver Spring, MD 20910

John Tracy Clinic
906 West Adams Blvd.
Los Angeles, CA 90027

Communicating with the Hearing-Impaired Child: The Aural-Oral Approach

by Geri Nelson, M.Ed.

What is the aural-oral approach to communication?

The basic problem of a hearing impairment is communication—the exchange of feelings, ideas, and information with others. Children with hearing impairments need help to develop the tools for communication.

Some of these tools are:

- Facial expression and body language
- Gestures
- Oral language or speech
- Reading and writing
- Sign language.

The aural-oral approach to communication leads to oral language or speech by developing the child's usable hearing—the child's *aural* skill— to **understand** spoken language and by developing speech—*oral* skill—to **express** spoken language.

The approach is based on the idea that children with hearing impairments can develop the tools for communication in the same ways as do hearing children—they just need plenty of special help.

How does a hearing impairment affect oral language?

Children with normal hearing learn to understand language and begin saying words without any apparent effort. Parents notice that children begin to understand and say more words as they get older, but they are probably not aware of all the steps children go through before they can understand complex sentences and tell complicated stories.

But your child has a hearing impairment; as you help your child learn to understand spoken language and to use speech to communicate, you will become very familiar with the different stages.

How can I help my child begin to understand spoken language?

You have already begun! You communicated the first time you talked to your child in that playful sing-song voice that people use only with new babies, or soothed your fussy baby with a soft voice. By exchanging feelings with your child, you communicated. With a few simple skills and the help of a hearing aid to amplify the sound of your voice, you will continue this parent-child exchange.

Children with normal hearing may listen to a word thousands of times in many different situations before they begin to understand it. Children with hearing impairments need these same listening experiences. But they need special attention to alert them to the importance of the sounds of language and to give meaning to them.

Here are some things you can do to help your child become aware of the importance of spoken language and its meaning:

Talk directly to the child. Get down to the child's eye level or bring the child up to yours. Try putting the child on the table or counter to talk about what you are doing.

Keep it simple. Use short, simple phrases and sentences. Don't talk baby talk, but don't talk adult talk, either.

Use lots of facial and body expressions. Use the child's eyes to alert the ears that something important is about to happen.

Use a natural tone of voice. You don't need to speak more loudly, but do speak clearly and not too fast.

Talk about the things that are important to your child. When your child points, gazes, or cries, try to understand what your child is trying to communicate and put that message into words. Say: "Oh, you want a cookie. Tell me, 'I want a cookie, Mommy.'"

Repeat words and phrases as often as you can. Say the same things over and over, not mechanically but in a playful way.

As part of the dressing routine, say: "Time to put on your shoes. Here are your blue shoes. Do you want to wear your blue shoes today? Okay, one shoe, then the other shoe. Now you have on your shoes." In that short conversation, your child will hear the word *shoe(s)* six times. Repeat that every day and it will be heard 2190 times in one year! That kind of repetition develops understanding.

Remember: Your child needs to hear and understand spoken language **before** using speech to communicate.

When will my child talk?

Children with normal hearing may listen to talk around them for more than a year and understand many words before they even attempt to say any words. Children with hearing impairments go through the same stages of listening-understanding-speech, but they often require more listening experience.

Can I encourage speech development as my child is developing understanding of language?

Yes! As you are talk-talk-talking to your child, encourage the child to join in the conversation. Here are some stages of speech development:

Babbling. All infants utter meaningless speech sounds as they play with their voices. Encourage babbling by imitating your child's sounds.

Jargon. Children may make short utterances that sound like sentences but use no real words. Respond to the emotion or meaning the child is trying to communicate. Conversation is turn-taking. Jargon is a good way for your child to begin to take turns with you.

Single-word imitations. Children will begin to imitate single words as they become familiar and important to them. Make a big fuss over every single new word you hear! At first the child's words may sound only a little bit like the actual words, but this will improve with time and experience. Just enjoy each new word as it comes.

Telegraphic speech. After they begin imitating and using a few single words, children may begin to imitate more words in a sentence, picking out the most important words, as in a telegram. If you say: "Do you want to go with Daddy now?" your child might imitate you by saying "go Daddy" or "want go Daddy." Much later, the child will use the words independently. Encourage your child to imitate and use as many words as possible.

Independent use of phrases and sentences. Continue to respond to the message as your child begins to put more words together. At the same time, help to fill in the sentence as needed.

Every minute counts! Begin *now* to talk to, listen to, and enjoy communicating with your child.

Helping organizations
Alexander Graham Bell Association for the Deaf
3417 Volta Place, N.W.
Washington, DC 20007

John Tracy Clinic
Correspondence Course for Parents
806 West Adams Boulevard
Los Angeles, CA 90007

110

Total Communication with the Hearing-Impaired Child

by Geri Nelson, M.Ed.

What is total communication?

Communication is an exchange of information, feeling, or ideas. Some of the tools we use to communicate are:

- Facial expression and body language
- Gestures
- Oral language or speech
- Reading and writing
- Sign language and fingerspelling

Total communication uses some or all of these tools to communicate with a child who has a hearing impairment. Total communication includes all of the skills used in the aural-oral approach to communication, plus sign language.

Sign language uses hand movements to represent words. Some words do not have signs and are spelled out, letter by letter, with finger movements. This is called fingerspelling.

How can total communication help my child?

Many factors go into the decision to use total communication with your child, including the age of the child and degree and type of hearing loss. It's very important that your child develop a language system as early as possible, in order to express needs and wants and to receive information from other people.

Sign language used at an early age with speech often helps children learn to understand and express themselves with language. In total communication, the child hears the spoken word through the hearing aid. At the same time, the child sees the word form on your lips and sees you make the sign for the word. This helps the child focus on the importance of your words and, after many experiences, understand their meaning.

Young children with hearing impairments often learn to express themselves using total communication before their speech can be understood without the use of signs. Because they can express their needs and wants at an earlier age, some of the anger and frustration often felt by children and their families is eliminated.

If you always use speech as you sign and your child uses a hearing aid consistently, your child will begin to understand spoken words and sign language at the same time. Encourage your child to talk while signing, so the child develops both speech and signing skills. When listening and speech skills are *both* encouraged, the use of sign language will not interfere with the development of speech.

What are the different types of sign language?

The special education teacher working with your child will suggest a signing system for your child. Some signs vary among schools or areas of the country, but most signing systems fall into one of two categories:

American Sign Language (ASL). This signing system has a formal structure very different from English. ASL may use a single sign to represent a concept or idea that is usually expressed with several spoken words. ASL is used by most adults with hearing impairments to communicate with each other.

Manual English systems. These use many of the same signs as ASL, but are closer to spoken English. Usually, in manual English, each spoken word is signed. These systems include signs for different verb forms, synonyms, and plurals. Some form of manual English is used in most educational programs for the hearing impaired. Signed English (SE) and Signed Exact English (SEE) are examples of manual English.

Both systems use fingerspelling for words which have no established signs. Fingerspelling can be difficult for young children, but it becomes important as they mature and their language expands.

How do I get started?

Your child will develop language through the use of total communication in the same way that all children learn language, by repeated experiences communicating with others in the home.

The first step may be to enroll in a sign language class recommended by your child's teacher. If no class is available, get a good sign language book and refer to it for signs as you need them. Build your vocabulary by practicing from the book and with family members. Instructional video tapes are also available.

Begin using signs as you talk naturally with your child. Speak directly to your child, signing as many of the spoken words as you can. Use short, natural phrases and sentences. For example, use the sign for *bottle* as you say to your child: "It's time for your bottle. Do you want your warm bottle? Here is your bottle on the table." Add the signs for *want, warm,* and *table* as you learn them. Eventually, you'll be signing each word as you speak, so your child will see as well as hear complete sentences.

When your child points, gazes, or cries, use speech and signs to provide the words for the message your child is trying to communicate. When your child cries and points to the cookie jar, say: "Tell me, 'I want a cookie, Mommy,'" signing as many of the words as you can.

Some dos and don'ts for total communication

Do use natural spoken language to communicate with your child, adding signs as you learn them. The goal is to sign each word as you say it.

Do sign to your child while you use speech in a natural tone of voice. In total communication, sign language is an addition to speech, not a substitute for it.

Do encourage your child to speak while signing, even though the speech sounds may not resemble words at first.

Don't expect your child to begin signing sentences or phrases right away. Language is developed from single words, whether spoken or signed.

Do plan on expanding your signing skills as your child grows so you can stay ahead!

Do recognize that sign language can be a fun part of communicating with your child. Involve brothers, sisters, friends, and grandparents as much as possible.

For more information
Simmons-Martin, A. 1975. *Chats with Johnny's parents.* Washington, DC: Alexander Graham Bell Association.

For a catalogue of sign language materials
Gallaudet University Press
P.O. Box 400 Kendall Green
Washington, DC 20002

Note: Since total communication includes the skills in the aural-oral approach, a companion article, *Communicating with the Hearing-Impaired Child: The Aural-Oral Approach,* should come with this article.

COGNITIVE DEVELOPMENT AND PLAY

1: Child's Play: From Birth to Age 3
2: Development of Intelligence in Children: The First Three Years
3: Problem Solving
4: Sensory Exploratory Play
5: Planning an Optimal Environment
6: Music and the Young Child
7: Encouraging Your Child's Play
8: Making and Adapting Toys for the Child with Disabilities
9: How to Choose and Adapt a Toy for Your Child

Child's Play: From Birth to Age 3

by Linda M. Levine, M.Ed.

Babies play at every stage of development. Infants learn about how the world works by looking at their own hands, grabbing rattles, or hitting objects. Actions that are repeated many times, such as playing with toes, soon become more constructive as babies continue their physical development. Being able to sit up or move around the room allows babies to explore different kinds of playthings.

Toddlers use toys more creatively. As they approach the second year of life, playing alone—*solitary* play—isn't as much fun as parallel play with other children.

You can help your child develop skills and progress to more advanced kinds of play—encouraging more complex play helps children with important thinking skills and with the social understanding of what they can do and how competent they are.

As soon as babies can grasp with their hands, they explore toys by putting them into their mouths. **By 9 months,** mouthing toys is not as important or as much fun as banging, shaking, and dumping things.

By age 1, babies are putting objects into containers, and they understand that pushing a button or pulling a string can make things happen. The toddler learns what to do with a spoon, a cup, and a telephone.

It's exciting to watch how an **18-month-old child** uses objects to act out familiar activities like eating, drinking, and telephoning.

By age 2, children are able to use pretend objects in place of real ones: A block becomes a piece of pie; some paper becomes a cookie. At this age, children pretend to be the adults they see in their lives—mommies, daddies, and even doctors! Learning how to pretend is the beginning of dramatic play and is an important first step in learning how to play pretend games with other children. In learning how to play make believe, the toddler is becoming a creative individual.

What's my role?

As a parent, you have an important job in the development of your young child's play skills.

Babies need you to talk and sing to them, and to provide many kinds of materials for them to explore. Most importantly, you must let *the baby* choose the toys and activities. Offer many kinds of toys and activities, but stop when the baby is tired and no longer wants to play.

Toddlers need you to play with them in games they choose themselves. You can help by giving suggestions and helping children play in more complex ways. Withdraw from the play when your child can handle the activities alone.

It's fun to "play house" with a 2-year-old when the toddler is able to eat the pretend food you offer and feed you in return. The way *you* play helps your child learn about appropriate behavior.

Your child's special needs

Children with mild or severe disabilities may not develop play skills as quickly as other children. Their play develops in the same stages, but more slowly, and at later ages. If your child has a disability or developmental delay, you should provide lots of help and direction for play skills to move along from stage to stage.

If your child has severe physical or intellectual delays, you may need to help your child use feet, hands, eyes, and ears to explore objects. A child with disabilities—or any child at early stages of play—needs to experience how things *feel* (soft, rough, bumpy, smooth) and have the senses stimulated. You could stroke your child with feathers, or join in water play.

You may need to help your child focus attention in a mirror, or wiggle fingers and toes in the sand or water. Lots of smiles, hugs, and praise will encourage new play behaviors.

If your child has a milder developmental delay, you need to be aware of the next steps in play development and help your child reach those steps. A toddler playing alone needs encouragement to play near other children. The child needs help in learning how to play for longer periods of time with the same toy.

Your child may need help in learning to play appropriately with toys. Show how dolly can be fed and put to bed, or that mommy can be called by turning the dial on the telephone and talking into the receiver.

What toys and playthings are best?

For babies, it's good to have toys that you and the baby can look at together. Talking about and playing with toes, fingers, and other body parts is just as wonderful as having rattles or soft animals to touch, chew on, or shake.

After the first few months of life, give toys which your child can use to make something happen rather than just watch or listen to. A toy that pops back up when it is pushed over is better than a wind-up toy.

For a toddler, rings to stack are better than a toy that talks when a string is pulled.

Children are playful by nature. They want to play every chance they get, and they learn each time they play. Take advantage of that! Encourage play at every level to help your child develop better physical, mental, language, and social skills.

What are the usual stages of children's play from birth to age 3?

Solitary play. Children play alone with their own toys or activities and do not try to make contact with nearby children. This is the first kind of play; it continues with varying levels of sophistication as children develop.

Some play behaviors are:

- Manipulating, banging, shaking, visually exploring
- Filling-dumping
- Simple means-end play, such as pushing a button to make something happen

Onlooker behavior. The child is interested in the play of other children but does not join in.

Some play behaviors are:

- Functional use of common objects
- Functional play. Acts out familiar activities, understands "pretend" (such as eating imaginary food)
- Simple representational play. Uses objects appropriately, such as feeding doll or putting it to bed.

Parallel play. Children play independently but near each other. There is close contact but little if any mutual play. The toys may be similar but one child doesn't try to influence the other's play.

Play behaviors:

- Representational play with objects. Manipulates doll to do common things, such as look in mirror or kiss another doll.
- Combined representational play. Child does series of pretend activities, such as pouring and drinking pretend milk.
- Symbolic play. Pretend objects are used for real objects. Sand becomes a piece of cake, and a block can be a car.
- Role play. Child takes on role of familiar people.

Associative play. Children share, borrow, and lend play materials among themselves. There is usually no common goal, even though the materials may be the same or similar. Play is *sequential*—they act out simple daily routines, such as undressing a doll, washing and diapering it, drying it, and putting clothes back on.

Development of Intelligence in Children: The First Three Years

by Linda M. Levine, M.Ed.

> "When do I teach my child about numbers and colors?"
>
> "Will my child learn anything by just playing?"
>
> "My child has Down syndrome. Can I help her learn?"

Parents are anxious for their children's intelligence to develop quickly and well. The good news is that parents have the unique opportunity to raise the intelligence level of their children during the first few years of life—and have a wonderful time doing it. But it can be hard to know *what kind of stimulation* and *how much stimulation* to give.

Experts disagree as to just what intelligence *is,* but they guess that between 50 percent and 80 percent is inherited. That means that your efforts, plus your baby's own interest in what is happening, will have a lot to do with your child's intelligence. Motivation plays a key role in the way the baby learns.

The first two years of life are important ones for the baby's growing brain. When babies are exposed to sights, sounds, textures to feel, smells, and tastes, more connections are made inside the brain.

Children need both the active involvement of parents *and* time to explore on their own. Stimulate your baby but don't overdo it; it's easy to be so eager that you do all the playing and the baby does all the watching! Children who are pushed too fast often have problems with certain types of thinking skills. Excessive spankings or other harsh punishment can also harm a child's intellectual, physical, and social development.

Children learn by playing

Playing is natural, enjoyable—and maybe the most important way children learn to adapt to the world. For adults, learning something new means work. But for the child, learning is usually exciting and fun. Toddlers love to help wash the car, sweep the floor, or pull the weeds. This "help" can be fun or infuriating for the adult, but the toddler is learning about how things work in the world. Playing with real objects and imitating adults is an effective way for young children to learn.

Children need lots of time to play with real objects before they understand the meaning of letters and numbers. Don't think of *teaching* your child so much as *guiding* the child toward discoveries about how things work, where things fit, and why things act the way they do.

Just what is intelligence?

Think of intelligence as a kind of road. Each child inherits a certain potential for developing intelligence. The stimulation a child receives during the early years—provided by adults and through the child's own interests—helps develop that potential and helps determine where the child's intelligence winds up along the road.

A child might be at the "developmentally delayed" point in the road, at the point called "above average," or someplace in between. Children whose intelligence develops more slowly are just at different points on the road than are children whose intelligence develops more quickly.

Children with mild, moderate, or severe intellectual delays need stimulation to go further along the road. Children with severely delayed intellectual development may need the same kind of sensory experiences that infants and toddlers thrive on.

Sensory experiences are where intellectual development begins. Children explore and understand the environment through their senses. Young children learn best from experiences that involve more than one sense, so provide many objects that can be tasted, seen, smelled, heard, felt, and played with.

Gentle touches, patting, tickling, and rhythmic movements are naturally stimulating for baby and for children whose intelligence is developing at a much slower rate. Stroking with a soft baby brush, cotton ball, or piece of velvet, or gently massaging arms, body, and legs are good ways to put children in touch with their own bodies. You can also stimulate your baby's senses by giving interesting things to look at or listen to.

Babies need to look at slowly moving objects, a variety of patterns, and bright colors. They need to hear adults talk to them and sing to them from the moment they are born! They need to hear sounds of things like clocks, rattles, music boxes, and cars. Long before they can talk, small children understand what is being said to them. The miracle of language development is intertwined with the development of intelligence.

What about memory?

Memory gets stronger as babies become toddlers. Being able to remember what took place in the past allows children to gather information, to compare it with old information, and to make new connections. The toddler who says "nana" as the car gets to Grandmother's house is showing good long-term memory. It's a big step when children use memory to relate what is happening to what has happened in the past.

Parents often think of early intelligence as knowing the names of things. This skill—*concept formation*—results after children have had many experiences and can link those experiences to a name. At first, any four-legged animal might be called "doggie." As children get older and focus on concept formation, the animals become cats, dogs, cows, and horses. It takes time for the thinking processes to mature, but how exciting it is to watch it happen, a bit more each day!

What can I do to help my child build intelligence?

- Create an atmosphere for learning and be sure your child is interested. Let the child lead the activity; stop when the child is bored, tired, or frustrated.
- Repeat those activities that your child wants to do again. They may be boring for you but enjoyable for the child.
- Encourage your child. Assure your child that making mistakes is a normal part of learning.
- Encourage active play. Running, jumping, and other active play is better than sitting in front of the TV or watching adults play.
- Keep a variety of toys and books on low shelves where your child can reach them. Introduce new toys one at a time. Too many toys can overstimulate a child.
- Help your child use the senses—hearing, seeing, touching, tasting, and smelling—to explore objects. Focus on one sense at a time.
- Talk a lot as your child explores. Talk about what is happening and what you are doing.
- Provide toys that allow baby to see cause and effect. Pushing a button to make a cat appear is not as stimulating as hitting a pan with a spoon and seeing it move, or hearing the noise.
- Provide activities at the child's developmental level. Allow the child to choose which toys to play with.
- Work as a team with your child's teacher or therapists. Share ideas and solutions. Together, you can help your child live up to full potential, at school, at home—and in life.

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Problem Solving

by Kathleen Walden DeVerna

To borrow an ancient proverb, if you solve a child's problem, you help the child out for the moment. Teach the child to solve the problem and you help the child for a lifetime.

Problem solving for young children

Life is full of problems. Some are big and others are small. But no matter who you are, solving problems is a big part of life. How this is done affects what is learned and how one feels about oneself.

What kind of problems are we talking about?

Adults face the problems of providing for their families, keeping a home, and working with others. Brothers and sisters have to figure out how to share their room, their toys, and their parents' attention. A developmentally delayed child might need to work quite hard to keep up with siblings and to adapt when keeping up is just not possible.

Even babies and young children have big problems to solve. First, they have to deal with the experience of birth. Then they face a new world of sights, sounds, and feelings. Take a few minutes to watch a hungry baby. Notice how the baby's head automatically turns toward the breast or bottle—the baby has just solved the very important problem of eating.

Childhood is full of problems that adults may not even notice. But children do—they are constantly challenged by new situations. To move, a baby needs to learn to control the whole body. Rolling over becomes important to get something that is out of reach. For a child, getting others to understand is a very complex problem. Each of these situations brings important opportunities for learning.

How can I help my child learn to solve problems?

Children need to learn to solve their own problems. You need to provide support, but only *when* it is needed *the way* it is needed.

Watch your child. What interests your child? What problems come up? How does your child solve them? Some children will try very hard; others are easily frustrated. Knowing how resourceful your child is and how much stress your child can handle will help you know when your help is really needed.

Wait. Problem solving takes time. First, the child must know there is a problem. If you do everything for your child, this won't happen. Then allow enough time for your child to think up a solution. Sometimes the solution will be based on previous experiences and sometimes it will simply be trial and error—a guess. Finally, your child needs the chance to carry out the plan. It might work or it might not, but your child will learn something valuable either way. If it works, your child will know how to handle other, similar problems. If it doesn't work out well, the child can try another way. Don't offer unneeded help; there is a great deal of learning from these small struggles.

Provide support when it is needed. Know when your child has had too much. Be ready to give help and encouragement. By being available and responsive you will teach your child to trust you. Your child will have the confidence to try new things if the child knows someone will be there if things get to be too much.

Be flexible. Expect your child to use the skills already learned. But children, like everyone else, have good days and bad days. It is not unusual for them to stop doing something they know how to do. Just try again later. As long as your child is generally working in the right direction, there is no need to worry.

Encourage your child to try. Show how good you feel when you see things working well. Children really appreciate a smile or hug for a job well done.

Structure situations so it makes sense to try new things. As your child develops, change each situation so it becomes more challenging. Place a toy a little farther away or do a little less to help with an activity. See if your child tries to do a little more because you expect a little more.

Join in your child's play. Let your child set the pace sometimes. Share the things that interest both of you. Let your child know that you really value the things your child likes.

Show how *you* solve problems. If a shoe is too far away, talk about the problem. Then work together to find a solution. ("Oh oh, the shoe is too far. How can we get it?") See if your child knows what to do. If not, go together and find a stick to get the shoe. Your child will learn from listening to what you say and watching what you do.

Make sure the area is safe. Look at the room from your child's point of view. If you need to, get down on the floor and crawl around. Check for hazards that make exploring unwise or unsafe. Arrange the room so there are few restrictions. It's okay if some things are still off limits. But if you need to stop your child's play often, make some changes in the way things are set up.

Practice is important. Children do things over and over. They practice until they are satisfied that they really understand how something works. This builds a good foundation for other skills. Interrupting this practice too often may discourage your child. It may also shorten what, otherwise, might have been a long attention span.

Love your child openly and honestly. Your child is a valuable person. Don't be afraid to show how much you care.

Summary

It is not easy to watch children struggle. It is hard to wait for them to solve problems. But the problems your child deals with bring great opportunities for learning.

Teach your child to respond to these challenges and you have taught an important skill. You have prepared your child for the future. Encourage your child to solve the small problems and, perhaps, the big ones will be easier.

Sensory Exploratory Play

by Judith C. Vestal, M.A., O.T.R.

What is sensory exploratory play?

We all learn from our senses. We learn from seeing, hearing, tasting, smelling, and touching. We also learn from the sensation of movement. Your play—and your child's—should include all of these sensations.

When do we begin learning from our senses?

Newborns already prefer some sensations over others. They respond to things that they see. They enjoy the sound of the human voice and prefer sweet tastes to salty or bitter ones. They prefer smells that are pleasant to those that are strong and pungent.

Babies also have preferences in the things they feel; they prefer soft silky fabric or human touch to the feel of a rough towel. As babies get older they tell different sights, sounds, smells, and textures apart and learn what various sensations mean. They know that the higher-pitched voice is mom and the lower-pitched voice is dad, and that food is coming when they see the bottle.

As physical skills improve, babies explore with fingers and hands. They love to experiment with textures, often smearing things such as pudding, mashed potatoes, or water.

How can I help my child use the senses to explore and learn?

Birth to age 1: Hang mobiles and objects across the crib to provide new sights. Play new sounds on a tape recorder. Give chances to both smell and feel during bath time by using a scented soap and rubbing with fragrant lotion and powder.

Rubbing, cuddling, and stroking are very good if your child feels stiff or floppy. Children who tend to be stiff respond better to slower, relaxing stroking; children who feel floppy enjoy vigorous, rapid movement and massage.

As soon as babies can keep their hands open they can explore different textures. Attach objects securely to a rope or dowel and tie it across the crib. Use things that won't come apart or break, such as:

- Hair curlers
- Thick colored yarn (that won't break or fray)
- Jar lids
- Plastic rings.

Your baby also explores smells. When cooking, let the baby smell different spices, such as cinnamon, cloves, mint leaves, and lemon and orange peel. Dip a teething ring into pudding, yogurt, or other sticky substance to provide new tastes.

The older baby can sit without support, so the hands are free to play. Hang toys from a frame so they won't roll away. Touch and taste can be explored by finger painting with pudding or yogurt. Cooked spaghetti can be squashed between the fingers, pulled apart, and thrown.

Bath time is a wonderful time to explore with the senses. Water can be poured through fingers, and hands can slap water to make it splash. Give extra support if your child can't sit in the tub without help—a plastic laundry basket with mesh sides gives support and won't trap water. If your child is visually impaired, give help in locating toys in the bathtub.

Babies enjoy sound games as they approach their first birthdays. Hide musical toys or sound-making objects so your child can locate them. The visually impaired child might need some help. The first time you play the game, place the sound nearby so your child finds it easily.

The 1-year-old explores by touching. In a special drawer, keep objects that are safe to touch and play with (such as a wooden spoon, a strainer, a funnel, an old pan, or an old magazine).

A flashlight is another toy for this age. Children love to examine the switch and shine the light in a darkened room.

Noisemakers give practice in telling different sounds apart. Fill salt or oatmeal boxes or film canisters with noisy objects (such as oatmeal, raisins, or old measuring spoons). Make these in pairs so your child can match the sounds.

You can do the same kind of matching with smells. Put herbs, onions, garlic, lemon, etc., in small pimento or baby-food jars. Cover the jars with contact paper. Let the child match the smells.

Different textures can be explored with a "feely" bag. The bag might contain feathers, scraps of burlap or other textured fabric, and objects which might be rough or soft.

Sand and water play is fun, too. Your child can feel the dry sand as it runs through the fingers and can make imprints in the wet sand. Macaroni or beans also pour nicely.

Cooked clay dough is another good material for play and sensory stimulation. Here is a recipe:

1 cup cornstarch

2 cups baking soda

1¼ cups water

Mix the dry ingredients in a saucepan. Add water. Bring to a boil, stirring constantly. Boil about a minute, until mixture is the consistency of moist mashed potatoes. Spoon onto a plate; cover with damp cloth. Refrigerate in a plastic bag.

The 2-year-old touches and tastes everything, so keep electrical outlets protected and electrical cords out of reach. Store breakables on high shelves. Two-year-olds explore anything which provides a new feeling or a new sound (such as sand, mud, bugs, and leaves).

The 2-year-old is able to match textures—cover pairs of blocks with different textures. It's easier now for the child to identify different household smells; play name-the-smell games (such as soap, coffee, and bacon).

The 2-year-old also enjoys games that require telling the difference between wet and dry—a big help if you're working on toilet training. Ask if the child is dry, and give praise when the child says correctly that the pants are dry. If the pants are wet, comment that the pants are wet. Another way to teach wet and dry is to show how clothes go into the dryer wet and come out dry.

The 3-year-old is learning more about the world. Imitation is how 3-year-olds act out this understanding; they "bake" mud pies, "drive" a car, and "sweep" the floor.

The 3-year-old also enjoys water play—blowing bubbles, splashing, finding toys hidden in soapy water—and sand play—pouring, filling, and emptying. Hide toys in sand to encourage exploring. Make textured finger paint by mixing the paint with oatmeal, dry beans, etc. Many materials are good for finger painting—try frosting, yogurt, jelly, or mashed potatoes. The visually impaired youngster may not enjoy playing with unfamiliar textures; the texture will be more acceptable if you let the child do the mixing.

Summary

Sometimes, the things we see, hear, or feel must be interpreted for us in order to make sense. You can help by providing a variety of experiences and by helping your child understand what the experiences mean.

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Planning an Optimal Environment

by Elyda S. Elwinger, Ed.D., O.T.R., CCC-Sp.

As a parent, *you* are the most important person in shaping your child's life and personality. You develop and manage the home, which is a complete world where your child grows and learns. You provide a quiet place for sleeping, food, and social contact. You give love and learning experiences. You are a role model.

The home can be part of the therapy for your child. It's vital that you plan the best environment possible; your child needs sameness, newness, comfort, and structure. Everything is important—places, things, and the language and emotions which surround children and activities.

What is environment?

Feeding, dressing, bathing, and sleeping are all part of the **physical** environment. It means physical comfort. It includes warmth, fresh air, and sunshine. Space to play is important—when children are contented and secure, they are ready to learn and grow.

The **social** environment includes contact with parents and friends. Children imitate those around them. They learn language as they hear it spoken around them. Being with others teaches them how to ask for what they want ("Cookie?") and how to take turns. They create order in their world by giving names to the things around them ("See doggie."). They tell themselves what to do ("Play mama." "Make car go.").

The **emotional** environment provides safety and comfort. It sets the stage for trust and growth. Secure children are loved and happy. They can move out into the world and learn. They know they can come back to a familiar place when the world becomes too much to handle.

A **safe** environment is also important. It's easy to miss the many dangers in the home until children start to explore:

- Who would think that a crawling child could pull up, fall in, and drown in a toilet?
- Wall sockets are charged with deadly electric shock. Are your unused outlets covered with protective plugs?
- Unguarded stairs invite a tumble. Do yours?
- Many cleaning supplies are dangerous. Do you store yours under the sink or up high, out of reach?

Children need to be free to explore and learn to function in their expanding world. You can protect your child from obvious dangers and oversee your child's play. It's better to "baby proof" the house than to confine your child to a playpen.

What do good environments provide?

Primary needs are met. Food, comfort, sleep, love—children need all of these to grow strong and healthy.

Social contact is provided. When you talk and listen to your child, you teach the child how to get along with others. Your child's responses—laughing, talking back, and even nonsense sounds—encourage your own efforts to communicate.

Environmental interactions—seeing, feeling, touching, and exploring fun things that are suited to age levels—promote learning. Planning is an important part of a good home environment. Keeping to a regular schedule is very helpful. Your child will expect bedtime and will fuss less if it always comes after supper. Feeding makes children sleepy, anyway, so this is a nice sequence. There is comfort and security in knowing what will happen next.

Structure also helps parents be organized. All bath things are together. Toys are in one place. Having things organized will give you more time for playing, talking, and learning with your child. Structure doesn't mean being rigid; sometimes it is necessary to change your schedule.

How can I provide a good environment?

Schedule: Respect cycles of sleep, hunger, and awake times. Don't go out to eat at nap time. Be firm about bedtime—staying up often makes children too excited to sleep. Also, children are not social eaters; good behavior at a restaurant is good timing or pure luck.

Language: Talk to your child, even if the conversation is one-sided. Language is often delayed in children with disabilities. You will have to assume greater responsibility, doing most of the talking—and most of the responding. Talk to your child, wait for a response, and then answer, even if your child does not respond.

It's hard to keep reaching out when your child doesn't know how to respond. Encourage eye contact when you talk with your child. As a way to include your child in daily activities, describe aloud what you are doing ("What shall we have for breakfast? Scrambled eggs sounds good. Let's get out the butter.").

Mobility: Children learn to move about and explore their world. Moving helps them learn where they stop and the world around them begins. They learn to roll over, to stretch, to reach, to creep, to crawl, to stand up, and to walk around. Children with disabilities may be slower in doing all of these activities. Encourage and help your child to try.

Moving around teaches children how to go after desired things. They get exercise and learn how to make their bodies work for them. They can move out into the world, instead of having the world come to them. They take a step toward independence. Children get a powerful sense of feeling good about themselves when they can say, "I can do it by myself!"

Self-help: Being able to control the nearby world, even to a very small degree, helps develop a good self-image. Being independent helps your child's self-esteem. Eating a cookie without help, taking off shoes (undressing is easier than dressing), calling to show you something—these are all steps in growing up and learning to live independently.

Play time: Encourage appropriate play activities. Much of children's play is also a means of learning about and controlling their surroundings. Children practice putting toys inside of boxes, pegs in holes, all things in their mouths. All of these activities improve eye-hand coordination, skill, and knowledge.

Children think they're playing, but they're really working to understand their world. Later, they'll practice and imitate what they've learned (feeding a doll, steering a make-believe car, washing toy dishes).

Plan for play time in the daily schedule; it's just as important as feeding, dressing, napping, and bathing. Select toys your child needs at each stage of development; play time is best for learning new things. Expensive toys are not necessary. Infants and very young children need toys that do not need tiny fine-finger movements. Toys that are easy to grasp teach children how to use both hands together. They learn how to put things together and take them apart, how to hold on and how to let go.

As children grow and develop better finger movements, toys can become more complex, with more pieces that fit together. Large, brightly colored toys are best, since young children are clumsy. Some children like toys with wheels on them. Others are more interested in balls to roll. Your child should learn to play with all kinds of toys, but remember your child's own special interests when you pick toys for free play time.

Summary

The environment you provide shapes the way your child grows and learns, responds and behaves. The best environment for your child is one that is safe, comfortable, and loving.

123

Music and the Young Child

by Kathleen Walden DeVerna

Children love music. They love to hear it, and they love to make it. Making music is fun. It's also one of the easiest things a child can do.

Adults tend to be much more critical than children when it comes to making music. You don't have to be a professional singer or dancer to perform for a child—children don't care if the tune is correct, the words exact, or the pitch perfect. They only care if it is fun.

And, even though it is fun, children learn a great deal through music. It is an excellent way to help them increase their social, physical, and communication skills.

How will music help my child's social skills?

Children feel important when they make noise that pleases themselves or others. Music is a socially acceptable way to practice doing this.

It is a good way to show emotions. Whether a child is happy, sad, frustrated, or excited, music can help express the feeling. Banging very hard on a drum is a good way to say "I'm mad!" Humming a familiar tune can be very comforting.

Children learn to cooperate when they share instruments or take turns while singing or dancing together. Friendships develop as children listen to or copy other children.

How will music help my child's physical skills?

Exercise is more fun when it's done to music. Play a favorite recording when you do alerting or relaxing exercises. This can help your child anticipate and take part in what you are doing.

Music makes any movement a little more entertaining and may encourage your child to work a little harder or a little longer. Climbing stairs can be hard work for a child with physical delays, but it seems like fun when it is done to a song like "Jack and Jill Went Up the Hill." Crawling across the floor as a horn blows or a drum rolls may give just the touch to push your child to make that extra effort. Balance and coordination may be challenged with a song like "I'm a Tightrope Walker" by Hap Palmer. Even dancing together can be therapy when it includes stretching or positioning exercises recommended by a therapist.

How will music help my child's speech and language skills?

Babies love to look at faces, and singing makes you all the more interesting. Knowing when the "Bumble Bee" will "BZZZZ" baby's belly encourages memory skills. Remembering where instruments are kept is a good lesson in organization. Your child may be able to get an instrument independently or have to ask for help. By watching faces, anticipating games, and asking for things, your child is learning how to communicate.

In order for children to speak, they must know what things are called. They have to know that *spoon* is what the eating tool is called and the stuff in the bath tub is *water.* You can sing songs to describe almost any experience your child has- -a routine lullaby can explain bedtime; other songs may be about waking up, or bath time, or dressing.

There are many wonderful songs available on children's records and tapes, but you can make up good songs, too. Take a favorite nursery rhyme and change the words to suit the situation. Putting these everyday experiences to music is a wonderful way to build a good understanding of what words mean.

Quiet listening is good, too.

Noise—musical and otherwise—isn't always good; quiet time is important for all children. People quickly "tune out" constant sounds. New sounds can be heard when the TV, stereo, chatter and other noises are silent. The bath water running, footsteps on the stairs, or the creak of a door can ring throughout the house when other noises aren't too loud.

Outdoors, the rustle of leaves, birds singing, crickets chirping, and water running are all sounds of nature singing. Make sure you let your child experience all of these.

What about instruments?

Many people make their own instruments. They might tap a pencil on the table, or strum with their fingernails on a table. Babies and young children make their own instruments—they crumple paper and bang rattles just to hear the sounds. This may be noise to others, but it's music to them.

Instruments to bang, shake, and rattle

- Assorted rattles
- Sandpaper blocks
- Large stones to bang together
- Seeds for shaking in a can
- Drum (or pan and spoon)
- Maracas
- Xylophone
- Cymbals
- Tambourine
- Bells (bracelet, anklet, or hand-held)

Things to crumple and crinkle

- Paper: wax, foil, tissue, used wrapping paper
- Fabric: satin, taffeta, corduroy, net
- Leaves
- Clothing
- Stuffed animals

Instruments to blow

- Whistle
- Harmonica
- Recorder

Other musical toys

- Music box
- Musical mobile
- Door bell
- Clapping hand, stamping feet, snapping fingers . . .

No child needs all of these instruments; just choose a few that are interesting and that fit your child's needs and abilities. All instruments should be durable enough to stand up to hard use. Some families buy one instrument for each special occasion, lowering the initial cost and giving the child time to fully explore each instrument.

Regardless of whether you or your child sings, dances, or plays instruments, enjoy yourselves. Music is to have fun with! Music is an expression of pleasurable sound—there's no need for criticism. Find out what interests both you and your child. Sharing music can be an important part of your child's development.

Encouraging Your Child's Play

by Judith C. Vestal, M.A., O.T.R.

Play is how children learn about themselves and the world. It's how they learn to move and what they can do with their bodies. They learn the world of colors and numbers, and the names of objects. Many school skills are learned through play.

What is the parents' role in a child's play?

The only limits to a child's play are the child's imagination and the "tools" in the child's environment. You can give your child the tools by providing the right experiences at the right time. To help you know when your child is ready to learn a new skill, here's an outline of the sequence in which skills develop.

In what sequence does play develop?

At first, your baby looks and listens. Brightly colored mobiles hanging across the crib are good now. Your baby pays attention to voices and later will turn the head to find the source of a sound.

In a few months, your baby becomes more active and begins to roll from stomach to back. At about 4 months, fingers close around objects—now your baby can hold toys.

Your baby will learn to sit independently as motor skills develop. By **6 or 7 months of age,** hands will no longer be needed for support and your baby will reach for and hold objects more easily. As control increases in the small muscles of the hands and arms, your baby will begin to hold and explore toys, turning them over and poking at them. As this *fine motor* control increases in the hands and fingers, your toddler will want to take toys apart or try to put them in containers.

The 1-year-old is more active. Your child pulls up to a standing position, walks around furniture, and finally takes steps with your help. Independence increases as control of the big muscles—*gross motor* skills—continues to develop.

The 2-year-old enjoys being able to eat and dress independently—more or less. Fine motor coordination improves. The child likes to take off and replace container lids, makes identifiable strokes with crayons, puts together simple puzzles, and stacks blocks. As gross motor coordination improves, the child is more willing to try new activities such as steps and slides.

The 2½- to 3-year-old can stay with an activity for longer periods of time. The child colors more accurately and uses blocks and other building toys with more skill. The child can place shapes accurately in a shapes board. Toilet training is usually complete now. Independence in self-care increases.

The 3-year-old enjoys playground equipment and any kind of outdoor activity. Play becomes more imaginative—dolls have tea parties and an old wagon becomes a fire truck. Drawings begin to represent objects and are easier to recognize.

As attention span increases, the child is more interested in books. Your child will like to read about everyday activities or experiences such as transportation, animals, and the alphabet. Children at this age also enjoy music and moving and dancing to music.

What can I do to encourage my child's play?

There are many ways you can encourage your child to listen and look carefully. Cover a flashlight with different colors of tissue paper and move it from side to side or up and down. Your baby can focus on the light and watch as it moves. Place toys which make noise (such as wind chimes or a ball with a bell in it) in the crib, or hang them over it. Also, try playing a tape recording of a familiar voice near the crib.

Encourage early movements by placing your baby on a quilt on the floor. Slowly and carefully, lift the edge of the quilt so the baby rolls from stomach to back. To encourage grasping, give the child easy-to-hold toys. Make sure that toys which are likely to go into the mouth are safe, with no small parts to come loose or be bitten off.

The child who does not sit up independently still needs help—support the child in a sitting position in a corner of a sofa or in the corner of the room. That will keep the child's hands free for play. Use a low stool or box as a table.

Give your child household objects to use as learning toys. The 1- to 2-year-old enjoys bowls and pans and boxes for emptying, filling, and stacking. Measuring cups help teach how things fit together and give a beginning concept of size.

Let 2- to 3-year-olds help you match socks or clothing when you fold laundry—that's good practice for matching colors and counting everyday items. Imagination games (such as dress-up with mommy's and daddy's old clothing and shoes) are fun now.

Books and magazines are popular with most 1-to-3-year-olds. Make sure your child has a variety of toys, objects, and environments in which to play. Your child will play the games you provide and create new ones, too.

What about a child with a visual impairment?

The child who is visually impaired can use the hands to feel and do things. The child will depend more on hearing to find toys. The child can move to explore but may need help developing the confidence to reach out beyond the safety and security of the immediate space. Encourage reaching out and investigating by providing other clues, such as smells and sounds. Your baby might be enticed with a banana by first smelling it, or by a bell by first hearing it.

Books with pictures to feel or smell are better than traditional picture books. The child may need help understanding the relationship between different toys. For example, when dropping a block into a container, one hand might hold the container and one hand drop the block. Later, one hand can hold the container while the other explores the inside to retrieve the block. This helps the child learn about how the block and the container are related.

Your visually impaired child will enjoy inspecting the kitchen cupboards, climbing on furniture, and exploring while guided by your voice. Talk the child through the activity. For example, say: "You are up on the chair. Can you get down to the floor?" Talking through the activities of daily life helps the child learn the names and locations of parts of clothing, the process for toileting, names for different foods, and household tasks and routines.

The child can use words that indicate the location of objects (such as *on, in, before, after, over,* and *under*) only after learning the concepts. Gross motor games—such as walking on different surfaces, like an old mattress or innertubes—lets the child learn about the concepts and safely practice moving.

What about a child with physical limitations?

Physically limited children have the same play needs as other children but are less capable of using their bodies to get to desired objects or to explore them.

A child who is physically limited may need a scooter board or other wheeled device to move from place to place. Your child's physical or occupational therapist will help you choose the right equipment.

Some children may need heavier toys, or toys attached to the table with a C-clamp or suction cups. You can also attach toys to a toy frame.

Control over the environment gives children a sense of mastery. Toys operated by switches let the child drive the car into the stack of blocks, make the dog walk into the doghouse, or move the robot from one place to another. These activities also teach and reinforce concepts such as *in, out, up, down, over,* and *under.*

Summary

You can have a big impact on what your child learns through playing. By understanding the sequence of play development, you can modify activities for your child's special needs. Choosing the right activity at the right time makes play more meaningful and fun for your child—and you.

127

Making and Adapting Toys for the Child with Disabilities

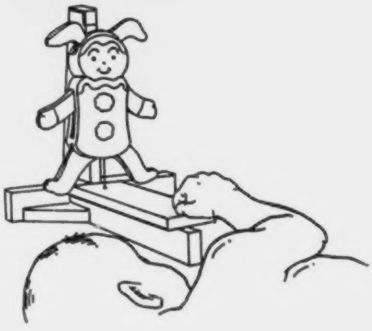
by Avtar Dunaway, O.T.R.

All children love toys. Toys are fun; they also help stimulate development. Your child probably wants to play with toys as much as any other child, but can't use many commercial toys.

You can easily adapt toys for your child. Here are ways to adapt three toys so that a small movement from the child will cause a big response by the toy.

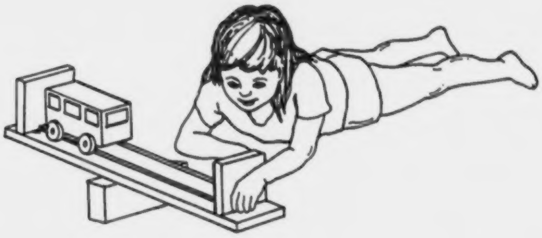
Toy: Any pull-string moving toy

Adaptation: Build a stand to suspend the toy. When the child pushes down on a lever attached to the stand, a string causes the toy to move.



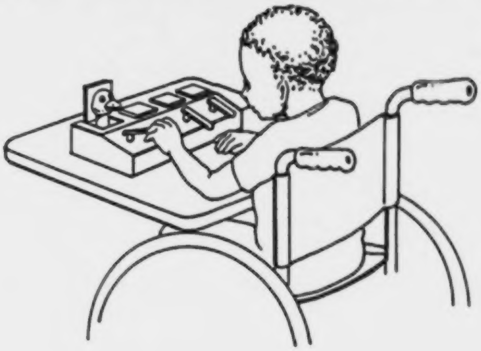
Toy: Any pull toy with wheels

Adaptation: Use any wheeled pull toy. An inertia-powered toy is best. The center track keeps the toy on the board; make the track higher to slow the toy down. Make the pivot on the bottom wider or taller as needed.



Toy: Any button-operated jump-up toy

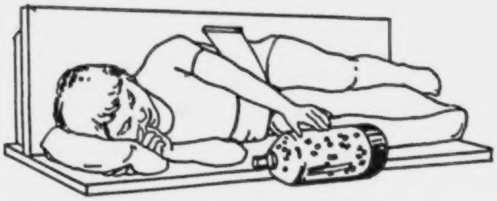
Adaptation: Remove the bell spring and add handles to the controls to reduce the force and effort necessary for the child to trigger the toy.



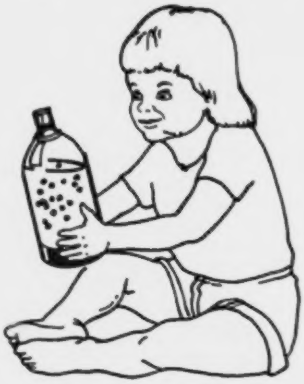
Toys to make at home

The rolling soda bottle. Clean a one-liter plastic soda bottle and half-fill it with water. Add pieces of foil confetti. Close the lid tightly and seal with duct tape. When the bottle moves, there is exciting, shiny movement inside the bottle.

Place your child's hand on top of the bottle. The confetti will move as the hand moves or slides off. To make the toy more exciting, add colored fish tank gravel to the water. This gives the toy an interesting sound.



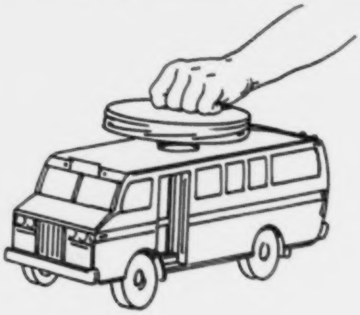
Or have your child roll the bottle to another person. Small individual-size plastic bottles also make a nice collection of rolling toys.



Adapted push-button vehicle toys. Downward pressure on the adapted button causes the toy to move forward. Some toy manufacturing companies such as Kapable Kids are now adapting these toys commercially.

Use hot glue to attach a jar lid to the button on the toy. Make sure the lid doesn't prevent the button from going all the way down. Fill the lid with foam rubber, so it's more comfortable for a child with a fisted hand.

Guide your child's hand to the lid and help the child push down. This toy can be used at the table, in sidelying, or sitting on the floor.



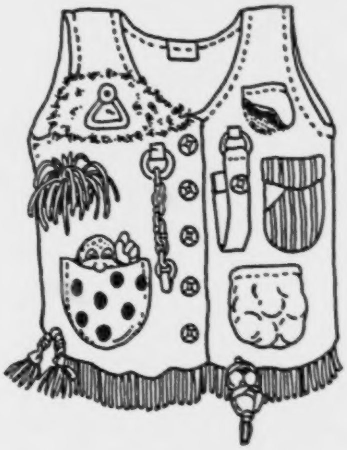
The activity jacket is useful with many different conditions and for all age levels, including:

Children who are restless in the car. You don't have to retrieve toys because the toys are attached to the jacket.

Autistic children who engage in self-stimulation behaviors. The jacket has helped many children move away from internal stimulation and toward external stimulation.

Make or buy a jean jacket-vest one size larger than the size your child usually wears. Use dental floss to sew on interesting items. Be sure items are too big to be swallowed or broken off.

Here are some things to use on the vest:



- Vibrators to put in a vibrator pocket
- A hook-and-loop fastener strip can be fun to pull apart and put together again. Attach a D-ring for easy grasping
- Leave a large pocket open as a place to put toys for your child to find
- Sew on tassels for little fingers to run through
- Sew on bean bags
- Put bells in a pocket and sew it securely shut
- Sew a crunchy sheet of plastic into a pocket
- Sew loops of hook-and-loop fastener in different places so you can attach new rattles.

Change toys often and move the pocket stuffers to different spots. The variety will make the vest more interesting for your child.

For more information
Kapable Kids
P.O. Box 250
Bohemia, NY 11716
(800) 356-1564

Brighter Moments, Inc.
Special Children Products
419 Nottingham
Irving, TX 75061
(214) 790-3298

Toys for Special Children
Steven Kanor, Ph.D., Medical Engineer
8 Main St.
Hastings-on-Hudson, NY 10706

The booklet *Opening Doors Again—Toys for Special Children* tells how to adapt 47 toys for use by children with limited movement. For a free copy, write:

Gene Schell
LTV Aircraft Products Group
Mail Stop 49L-11
P.O. Box 655907
Dallas, TX 75265-5907

Smart Toys for Babies from Birth to Two, by Kent Burtt and Karen Kalkstein, shows how to build toys at home and explains how to use the toys to help build thinking skills. The book was published in 1981 by Harper and Row.

How to Choose and Adapt a Toy for Your Child

by Jeannie M. Maldonado, M.S. Ed.

Buying toys for a child with developmental disabilities can be frustrating. But many battery-operated toys can easily be adapted for children with special needs. Here are some tips for buying and adapting a toy for your child.

Choosing a toy

Read the box. These often show the ages of the children who will have the most fun with the toy. If your child hasn't developed as fast as other children the same age, look for a toy for a younger age group.

What does your child like now? A bold child might like a toy that moves, or makes noise, or both. A quieter child may want a musical toy that is soft and cuddly. Does your child like to follow things? A small toy that rolls on the floor would be nice. A "slide" toy may work well if your child isn't able to follow the toy but can watch quietly for hours.

Start simply. Buy a small toy first. There are many inexpensive battery-operated toys that move. Later, you might want to adapt more complicated toys.

Look for battery-operated toys. Wind-up toys and dolls are okay, but they both need *you* to keep them interesting. Battery-operated toys move and entertain your child for hours. Some talk, needing you only to turn the tape over. Battery-operated toys are more fun for friends, brothers, sisters, and cousins, too; your child will have more people to play with. *Do not* buy toys that flip or turn in tight circles, because the wires will twist.

Adapting a toy

Why? Often, the on-off switch on a battery operated toy can be too small for your child to use. But some can be adapted so that any child can turn the toy on or off.

Which? Battery-operated toys with a switch on the body of the toy are easy to adapt. Toys with the battery pack and switch as a separate unit are slightly more complicated. These instructions are for adapting the simpler toy.

How? Adapting a battery-operated toy calls for *interrupting* the flow of power from the batteries to the motor and building a bigger *switch*. You will need:

A wire stripper or sharp knife

Rosin core solder (60/40) and a soldering iron

Speaker wire (24 gauge "zip cord")

Heavy aluminum foil

Construction paper

Hot glue and hot-glue gun

Long-nosed pliers

A subminiature roller lever switch (such as Radio Shack® 275-017)

An empty video cassette box

String (about 1 ft. long)

A hole punch or electric drill (¼" bit)

Scissors

1 dime and/or 1 nickel

1 plug and inline jack set (such as Radio Shack® 274-283)

A battery-operated toy with the batteries in it

Making the battery interrupter

1. Collect all the items you need.
2. Put the batteries in the toy.
3. Turn ON, then OFF, to make sure the toy works.
4. Plug in the soldering iron and the glue gun.
5. Cut out two circles of aluminum foil and one circle of construction paper. Use a nickel as a template if the toy uses C or D size batteries. For A size batteries, use a dime.
6. Cut a 6" piece of speaker wire.
7. At both ends, separate the wire for 2 inches.

8. Strip off the plastic insulation for 1/8 inch on the separated ends.
9. Put one stripped end of the wire onto one of the foil circles, near the edge.
10. Touch the hot tip of the soldering iron to the bare wire. At the same time, touch the solder to the tip of the iron. If the iron is hot enough, the solder will instantly flow onto the wire and foil. Lift the solder and iron, and wait a moment. The solder will harden, holding the wire to the foil circle.
11. Repeat the soldering process with the other stripped wire at the same end.
12. Use the glue gun to glue the construction paper circle between the foil circles.
13. Take the cap off the jack and slip it, rounded end first, onto the other end of the wire.
14. Locate the little hole in each prong at the back of the jack.

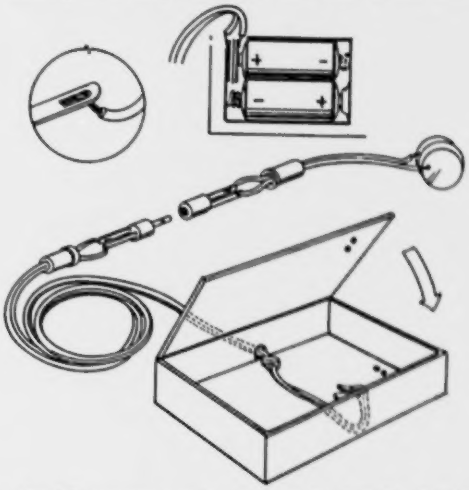
    Put one of the bare wire ends into one of the holes and press the wire flat against the metal.
15. Solder the wire onto the prong, using a small amount of solder.
16. Solder the other bare end onto the other prong.
17. Fold the metal points down around the wire to hold it in place.
18. Push the cap forward and screw it onto the jack.

    To test the battery interrupter, open the battery case. Put the sandwich of circles between one of the batteries and its contact. Close the case. Turn on the toy. If it doesn't come on, your battery interrupter is doing its job!

Making the switch

1. Punch a hole through the middle of the back of the video cassette box.
2. Break off any plastic pieces of the box that stick out.
3. Punch four holes, two on the top and two on the bottom of the box, opposite each other.
4. Cut a 3-foot length of speaker wire.
5. Separate and strip the wires at both ends.
6. Locate the small letters on the casing of the subminiature roller lever switch. Find the terminals marked "C" (common) and "NO" (normally open).
7. Solder one stripped wire to "C" and one to "NO."
8. Make a knot in the speaker wire about 6" from the switch.
9. Glue the switch to the inside of the front of the box. Mount it so the long side of the switch is along the box and the top is even with the top edge of the box. (The roller lever arm will be above the edge of the box.)
10. Pass the wire through the hole in the back of the box. The knot should come up against the inside of the hole, to take the stress if the wire is pulled.
11. Put the plug cap, rounded end first, onto the other end of the wire.
12. Solder on the plug, as you did the jack.
13. Tie a loop of string through the holes on the top and bottom of the box, leaving it loose enough for the roller arm to come all the way up, yet tight enough to keep little fingers out of the box.

    Push the plug into the jack and press on the lid to close the switch. The toy should start. The toy will run as long as you or your child presses, leans on, pushes, hits, or lies on the lid. Experiment to find the best place to put the switch for your child.



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PERSONAL CARE

1: Development of Dressing Skills
2: Dressing the Child with Low Tone
3: Dressing the Child with High Tone
4: Dressing the Child with Hemiplegia
5: Your Child's Personal Hygiene
6: Toilet Training

Development of Dressing Skills

by Kay Benjamin, O.T.R.

Much to their parents' frustration, children learn to undress long before they learn to put clothes on. They delight in practicing their undressing skills and in running through the house or yard quite naked. This common stage of normal development passes in a few months.

Here is the sequence of how dressing skills usually develop. The time at which each skill is acquired might vary by several months, but whether skills are late or early, the sequence is usually the same.

The first year

As early as 10 months: may be accustomed to the dressing process. Helps pull a leg from a pants leg or an arm from a sleeve.

Between 10 and 12 months: cooperates by pushing arms into sleeves and legs into pants. May raise a foot upon request when the shoe comes into sight.

12 months: may remove shoes if you loosen the laces.

The second year

13 months: stiffens neck as shirt is pulled over head.

16 months: deliberately removes hat and socks.

18 months: can put on a hat, unzip a large zipper, and remove an unbuttoned button-type shirt.

18 to 24 months: will probably be able to undress from some outfits without help. This is when you may have the child ready to leave the house, turn your back, and turn back to find a naked child!

24 months: puts on shoes with only a little help. This is a good age to practice unbuttoning large buttons. May begin to pull pants off without help. A few months later, will help pull pants back up. This is good timing as you begin to think about toilet training.

The third year

26 to 30 months: undresses from a variety of outfits with only a little help.

30 months: hangs clothes on a hook when you request.

30 to 36 months: fastens large buttons and dresses fully. May need help to identify front and back and help with fasteners.

Beyond age 3

Children refine and get faster at skills they have learned. A 4-year-old will button small buttons and learn to lace shoes. Tying shoes will come around age 6; until then, hook-and-loop closures can add to independence.

How can I help?

From the first few months of life, dress your child in a routine way. Describe what you are doing as you go along. Little phrases such as "give me your foot," "over your head," and "where's your arm?" can become meaningful if you use them each time you dress the child.

Expand your child's vocabulary and make dressing a learning time by saying the names for different articles of clothing. Always give your child a chance to help with dressing, especially from 10 months on. At that age, you might pause a moment when you have placed the child's hand in the sleeve. Applaud and give praise when the child pushes the arm through.

After 14 months, naming the clothing becomes even more important as your child learns new words. Take advantage of your child's natural urge to imitate—give more help with one side and let the child do more to dress the other side.

At this age, children understand that the shoe goes on the foot but haven't developed the muscle coordination to get it there. Lend a hand when necessary—help your child to succeed. You don't want your child to give up, but you also don't want to show that only *you* can do the job.

Develop some fun dressing rituals to encourage cooperation and participation. Make up a little song; play peek-a-boo as the shirt goes over the head. These can make dressing go faster, too.

Your older toddler will develop a surprising interest in clothes. The child may insist on choosing the clothes or balk at your choices. Make sure the clothing your child chooses is comfortable; no one likes heavy, cumbersome, or binding clothing. It may satisfy the need for independence if you place two choices in a drawer for the child to decide between. That way, the outfit will be acceptable to you and the child's opinion will be respected.

What to look for in clothing

Your child will probably outgrow clothes before they fall apart, so look for bargains. Look for durable, simple clothes which wash well. If you buy clothing that is too big, it might look worn or faded by the time your child grows into it.

Look for clothes with large buttons, large, easy-gliding zippers, hook-and-loop fasteners, large armholes, wide sleeves, and big or stretchy necks. Pants, shorts, and skirts with elastic waistbands are much easier to deal with than those with zippers or snaps. Since tube socks are loose and stretchy and don't have a defined heel, they are much easier to put on and take off than the tight, nylon socks often sold for children.

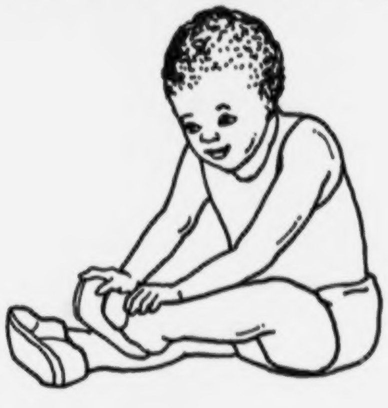
Don't be upset by dirty clothes. Dirt and stains are facts of life for babies and toddlers; neither you nor your child should feel bad about that. Just have a good supply of everyday clothes and save a few nice outfits for special occasions.

Other activities to develop dressing skills

Here are some ways to work dressing skills into your child's play:

- Put brightly colored bracelets on wrists and ankles to help develop body awareness.
- Let your child try on a variety of hats in front of a mirror, and fit your child's feet into grown-up shoes.
- Play dress-up games with a large button-down shirt and a T-shirt to practice pulling it overhead. If your child is sensitive to things being pulled overhead, encourage play with hats, necklaces, and bandannas.

Fasteners may be easier to learn if your child is not wearing the item of clothing. Let your child button a shirt you are wearing, or lay the shirt on a table so the child can see it well. There are a variety of books and dolls available which have fasteners for children to open and close.



Summary

Learning to get dressed is an important part of growing up and developing independence and self-esteem. Always encourage your child to move on to new skills, regardless of the child's age. Make sure your child has chances to help out at an early age—when your child is involved from the start, becoming independent will be easier.

For more information

Caplan, F., and T. Caplan. 1977. *The second twelve months of life.* New York: Grosset and Dunlap.

Leach, P. 1977. *Your baby and child.* New York: Knopf.

Dressing the Child with Low Tone

by Barbara Tracy, P.T.

As early as 10 months, your child begins to take part in the dressing process. At first, the child lifts an arm or leg to help. Usually, by age 5, a child can dress without help.

It's a positive experience for both of you when your child learns to dress and undress. Some of the benefits are:

- Improving hand and finger movements as your child becomes able to do zippers, buttons, and snaps.
- Increasing muscle strength in the trunk and extremities as your child learns to stay balanced with arms raised overhead.
- Teaching about body parts and concepts such as *in, out, over,* and *under.*

Low muscle tone can make moving and playing—and dressing—difficult for your child. The child may seem passive and unmotivated and may feel limp and heavy when held. Don't let your child lie passively while you do all the dressing; it's often easier to do the dressing yourself, but this may make your child even more passive. This can be frustrating, especially as your child gets older. Praise your child's early efforts to help.

Practice and repetition are the keys to learning any new skill. A child with low muscle tone generally requires more time to learn to dress. Allow enough time to make dressing enjoyable for you and your child. Describe in detail each step of the process.

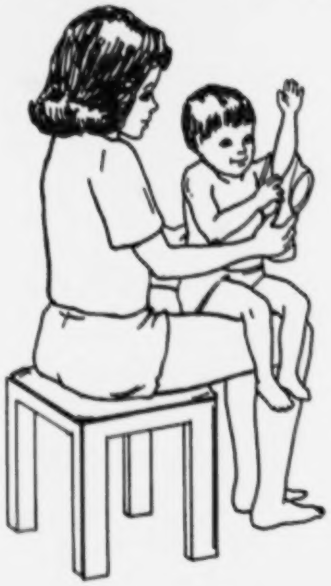
Positions for dressing

You can dress your child in many different positions. Use the same positions your child uses during play time, such as when the child sits without help on the floor or on a bench.

Infants. Usually, the very young child needs to be completely supported, lying face up or sitting on your lap. Even in these positions, your child should be encouraged to lift an arm or leg for you to place into clothing. As the child gets older, use positions in which the child does not depend on you for balance.

Sitting. Sitting is an excellent position for dressing, since your child can watch what is happening. Sitting helps develop strength and balance in the head and trunk. If your child sits on your lap for dressing, move the child toward your knees as balance improves.

Place your hand on the child's lower back if your child needs more support. This also gives a sense of security. Give less support as the child becomes able to balance without help.

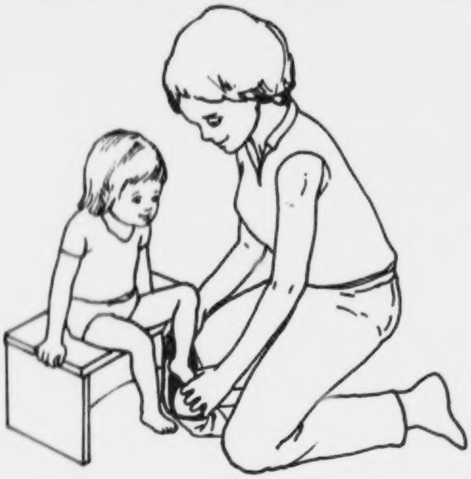


Your child can sit on the floor to dress, but don't let the child sit with legs wide apart and back rounded. For trunk support and to encourage better posture, place your child's back against a wall or other firm support.

Soft surfaces—such as beds and sofas—can make it hard for your child to balance. Avoid them.

The best position for dressing is for your child to sit on a chair or bench. This requires fairly good trunk balance, so the seat should be low enough for the child's feet to rest on the floor. At first, to help the child stay balanced, stand behind the child. Later, you may want to come around to the front.

In the sitting position, your child can lean forward to put an arm into a sleeve or pick up a leg to put it into a pant leg. Your child can also practice standing from a sitting position in order to pull up or take down the pants. To improve balance and coordination, have your child reach forward or to the side for clothing.



Steps to independence

Children usually learn to undress before they learn to dress. When your child is first learning to take off an item of clothing, help by removing most of the item and then let your child complete the action. For example, pull a sock past the heel and let your child slip it off over the toes. Put your hand over the child's hand and help until the child can do it alone. Teach dressing the same way—start the process and then help your child finish it.

Another approach is to have your child begin undressing or dressing and then do the final steps yourself. Have your child put an arm into a shirt sleeve; you finish by pulling the shirt up and over the shoulder. Again, each time you go through the process, have your child do a little more of the work.

Selecting clothes

The style of your child's clothing is important. Loose-fitting clothes are easier to get on and off. Avoid small buttons or zippers in the back. Hook-and-loop closures or large buttons are easier for the child to handle. Zippers will be easier to use if you attach loops to the tabs.

Combined therapy and dressing

Dressing can be a therapeutic activity. You can do many exercises to develop strength, balance, and coordination while you dress your child. Be sure to consult your pediatric therapist if your child has any special needs. Here are some easy ways to combine dressing and therapy.

To challenge sitting balance: While your child is sitting on your knees getting dressed, make small side-to-side movements of your legs or gentle up/down bounding movements.

Improving strength and coordination: Instead of pulling an arm or leg through clothing, tap the back of the arm or knee gently. This will encourage your child to actively push through the clothing.

Developing fine motor skills: Have your child help with large buttons or zippers.

To strengthen leg muscles: Going from sitting to standing while putting on pants helps strengthen leg muscles. Another good exercise is to provide slight resistance as your child pushes an arm or leg through a sleeve or pant leg. Don't prevent your child's movement; just slow it down so your child works a little harder.

Summary

It's important that your child learn to dress and undress. Make sure you give your child the time, help, and opportunity to practice dressing skills. Dressing is part of being independent, and it helps develop balance, strength, and coordination—all of which are important for many other activities.

Dressing the Child with High Tone

by Esther Kant, O.T.R.

Your child's high muscle tone can make it hard for you to dress your child, and it can make it hard to teach dressing skills. Here are some ways to make dressing more enjoyable for both of you.

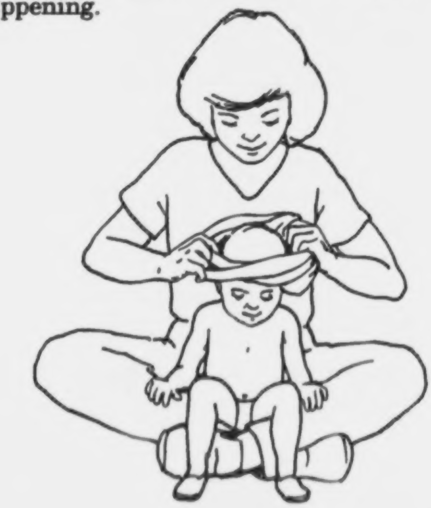
Time

Always make sure to allow enough time for dressing. Rushing can cause your child to become tighter, which makes dressing more difficult and frustrating.

What position should I use to dress my child?

One of the best positions is for you to sit cross-legged, forming a hole in your lap. Your child's bottom fits into the hole when the child faces away from you. To decrease tightness in the child's legs, make sure the child's weight is on the bottom and not on the lower spine. Support the child with your body if necessary.

This position leaves both your hands free. Sit in front of a mirror so the child can see what is happening.



Another good position is for you to sit on the floor with your child lying face up between your legs. The child's legs can be bent or wrapped around your waist. The child's head can be on the floor. Or, for more chin tuck—to help the child relax—support your child's head on your feet.

Talk about what you're doing as you dress your child. Name body parts; talk about *over, under, through,* and other dressing movements. Again, use a mirror so your child can watch. A mirror also helps when the child begins to dress independently.

What position is best for my child to dress without help?

For independent dressing, it is best for your child's body to be bent or flexed. The child can sit in a chair, or on the floor with the back against the wall. If using a chair, the child's hips should be bent to at least a 90-degree angle and the feet should be flat on the floor.

What kind of clothing should I buy?

Here's what to look for when you buy clothing for your child.

Fit: Loose clothing is best, either a size or two too big or made from stretchy knit fabrics. Avoid turtlenecks unless there are snaps at the neck.

Style: Shirts with buttons are often easier to put on and remove than pullovers.

Snaps at collar and crotch.

Elastic waistbands for pants.

Winter clothes: Look for long zippers on snow suits, mittens without thumbs, and boots that go over shoes. Put plastic bags over the shoes to make it easier to remove boots.

Socks: Tube socks are much easier to put on than are socks with heels.

How can I adapt my child's clothing?

Hook-and-loop fastening material is available at most fabric stores. You can use it in a number of ways. You can:

- Sew it into a seam to make the opening bigger.
- Add it to the collar and shoulder to make the opening for the head bigger.
- Put it under buttons or all the way down the front of an open shirt to make the shirt easier to open and close.

- Put it in the arm seam of a snow suit or jacket to make it easier to get tight arms in.
- Snaps, buttons, and elastic can also be used to make openings bigger and make clothes easier to put on.

Putting on shirts and dresses

Make sure that all fastenings are open. Seat the child in your lap. Put the head hole over the back of the child's head and pull forward and down—that will maintain a good chin tuck and help keep your child flexed and relaxed. If one arm is tighter than the other, put the tight arm into the sleeve first.

Don't pull a tight arm through the hole by pulling on the hand. Instead, push or tap from behind the elbow to straighten the arm, or shake and relax the shoulder to help relax the whole arm. When undressing, take the looser side out first.

When your child begins trying to dress independently, it may be easier for the child to first reach into the sleeves. Then slide the sleeves on, doing the tighter arm first. Finally, hold the head opening with one hand and stretch it over the child's head.

The "upside down" method is another way for your child to put on shirts and jackets that close with buttons. Place the garment on the floor or on your lap. The collar should be toward the child and the front should face up. Have the child reach into the arm holes and then lift the garment up and over the head. This method does not work well if both arms are very tight.

Putting on pants

Make sure that all fasteners are open. Have the child sit in your lap with hips bent, so the legs are relaxed. If one leg is tighter than the other, dress the tight leg first.

When pulling the pants up over the child's bottom, help the child bend forward from the hips to raise the bottom and keep a relaxed position. When dressing without help, your child can use the same positions in a chair or on the floor.

Another way to pull up pants is for the child to lie face up on the floor, bridging or lifting the bottom while the knees are bent and the feet are flat on the floor. Use this position only if the child can stay relaxed while lifting the bottom.

Your child can also pull pants up while standing. For extra support, the child can lean against a wall.

Putting on socks and shoes

Tube socks are easiest because there's no heel to worry about. Socks should be loose fitting; tight socks are very difficult to put on. If your child is sitting in your lap, hold the knee, hip, and foot bent as you put the sock on. To involve your child, bring the child's hands forward and have the child hold onto both sides of the sock.

To put socks on without help, the child should put both thumbs into the top of the sock, stretch the opening wide, and then pull the sock up over the foot.

Shoes—especially orthopedic shoes with braces—can be very difficult. Open the laces as much as possible. Bend the leg and foot as you do for socks. It is very important that you bend the foot up at the ankle. If you don't, the toes will probably be tight and you won't be able to get the shoe on.

If the shoe won't go on smoothly even with the foot bent, don't force it. Try moving the shoe gently from side to side as you work it onto the foot. This often relaxes the toes and allows the shoe to go on.

Your child can do the same when dressing without help. When putting on shoes, it often helps to cross one leg over the other. This keeps the knee bent and turned out and helps to keep the leg relaxed.

Summary

Dressing is a time for you and your child to touch, talk, and learn. It's a good time to teach your child about body parts and body image. With preparation, the right clothing, and enough time, this daily routine will be much more enjoyable for both of you.

Dressing the Child with Hemiplegia

by Joan Peet Gettings, O.T.R.

Dressing is an important part of independence. Children with hemiplegia can learn to dress themselves; it's a daily activity which helps them feel capable and good about themselves.

Why does my child need special help?

Hemiplegia is paralysis of one side of the body—one side of the body feels and behaves differently from the other side. When the unaffected side of the child's body works really hard, the effort can cause the muscles in the hemiplegic or involved side to tighten.

Your child may avoid using the involved side. But if it is not used, the side will not grow and develop, and the limbs can become tight and very difficult to move. That's why it's important to use *both* sides of the body in *all* activities—especially dressing. Your child's occupational or physical therapist can show you the best ways to help your child.

What are some milestones for learning to dress?

Don't be in a rush to teach your child how to dress—most children take five or six years to learn to do the whole job. Here's what to expect as your child learns to dress:

12 months: Child starts to cooperate by holding up a foot for a shoe or an arm for a sleeve.

18 months: Child pulls off socks, unties shoes, and removes hats.

2 years: Child enjoys helping to undress.

3 years: Child wants to help with dressing.

By age 6: Child can manage knots and bows, buttons and zippers. Is well on the way to being independent.

What to do and how to do it

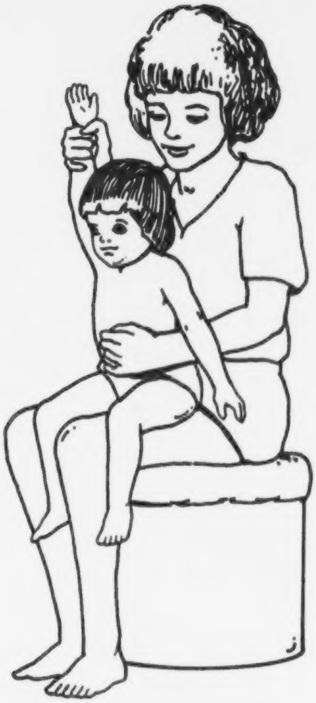
Use these special techniques consistently:

- Approach your child on the involved side
- Have clothes all ready before you start
- Provide a safe, firm seat—a chair, a bench, on the floor, or in the corner. The child should lean forward, bending hips and knees.
- Get your child's attention and talk about what you're doing.
- Before putting on the garment, prepare the involved arm by slowly stretching the arm up, higher than the shoulder. Bend the hip, knee, and foot on the involved leg before putting on socks and shoes. This helps keep the toes from curling.
- Encourage your child to look at and touch the garment and the body parts you are dressing.
- **Do not** force your child to use the involved arm for dressing. Just encourage your child to use it as a helping hand.
- When dressing, put the involved arm and leg into the garment first. Take them out last when undressing.
- Pulling fingers through a sleeve will only bend the elbow of the involved arm. If you need to pull, guide the arm from the child's shoulder. Then, hold the child's whole hand and gently rotate the thumb upward. Pull slowly as the resistance releases.
- Pull the sleeve up past the elbow of a straight involved arm, then pass the clothing around the child's back for the other hand to push into.
- To remove a T-shirt, pull it over the head from back to front.
- Have a regular time for your child to practice, such as before or after bathing, or during the weekend. Just before bedtime is a good time, too; pajamas are often the first garments a child takes off and puts on alone!
- Watch for signs that your child is interested in independence. Give help **before** the child is frustrated or disappointed. Praise every success.

Where should I dress my child?

Choose a place where you can comfortably support and help your child. Prepare the area first and have clean clothes handy.

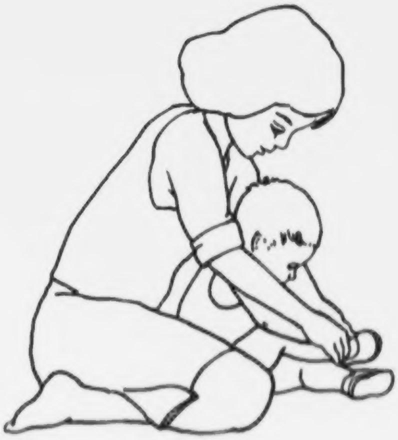
Across your lap. This is a good position for a younger child, since it lets you prepare the arms for dressing by stretching them from the shoulders.



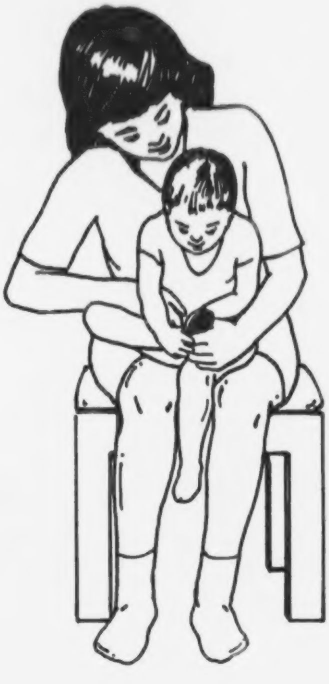
The position helps keep your child's head in the middle and brings the arms together. Gravity also helps straighten elbows and wrists. To finish up, turn the child while you do up buttons and tuck things in. For more sensory experience, have your child face in a different direction each time.

On the floor. This is a good after-bath position. It lets your child see clothes and body parts and lets you move easily as you help get involved limbs into clothing. If you need to lift your child out of the bath, hold the child's back close to your body and straighten your knees. If you use the bathroom floor, make sure the hot water pipes are insulated.

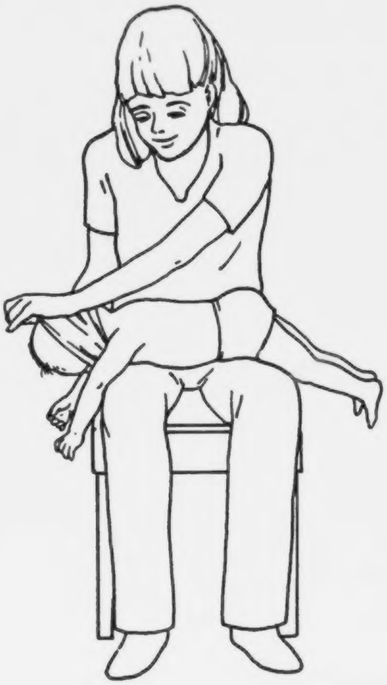
If your child needs help to balance when sitting, use your knees to support the child's hips. Take the support away as soon as you can.



Sitting on a chair with the child on your lap. This position lets you control the forward bending at the hips, helping your child keep shoulders and arms forward. Your child can see clothing and limbs.



141



What clothing is best for my child?

Good early dressing experiences will make your child more likely to want to be independent. The secret is to make the task simple. Large, roomy, stretchy clothes are a big help. So are tube socks and sweatsuits. Here are some more tips:

- Hook-and-loop fastener material is a great help. Shoes that fasten with it are easier for your child to use. You can also use it to replace buttons.
- Buy clothes that are a size or two too big.
- Make sure the head opening is large enough—boat necks are good.
- Replace small buttons with large ones or with snaps.
- Find shoes with long, wide openings, such as athletic shoes.
- Provide large-size dress-up clothes—hats, shoes, and jewelry— for lots of fun dressing practice.

Dressing: the skill

Dressing is complicated! Your child needs head and eye control and good balance and must know just where the parts of the body are. Later on, the child might need movements fine enough to fasten a hook and eye. The child needs to know that clothes have a top and a bottom, an inside and an outside, and a back and a front. There are colors to recognize and names of different pieces of clothing to learn.

Involve your child in the dressing process from the very beginning:

- Explain what you are doing and why.
- Identify clothing by name.
- Talk about where different pieces of clothing are worn and the body parts that must be moved in order to put them on.
- Talk about "push/pull" and "on/off," colors, directions, and the names of the parts of the body.

Encourage and praise every effort when your child tries to help. Let your child do the last step of the dressing process, as you slowly guide your child towards independence. The satisfaction your child will feel will last a lifetime.

For more information

Finnie, N. R. 1974. *Handling the young cerebral palsied child at home.* New York: E. P. Dutton.

Klein, M. D. 1983. *Pre-dressing skills.* Tucson, AZ: Communication Skill Builders.

Your Child's Personal Hygiene

by Joan Peet Gettings, O.T.R.

Hygiene—bathing, washing hands, and brushing hair and teeth—is a lifelong routine of independent daily life. You can help your child learn these important skills by doing the tasks regularly, in the same enjoyable, comfortable way, from an early age.

Bath time

Most children love bath time. When your child is well supported in a lap or suitable bath seat, bath time is a time for play, learning, and movement. But a slippery child on a slippery surface can be difficult to manage. Keep bathing safe and happy by planning ahead and preparing both the bath and your child.

Safety first!

Here are some steps to help keep bath time safe:

- **Never leave your child alone in the bath!** Have toys, soap, sponge, brushes, and towel nearby. Turn off the stove and iron and unplug the telephone. Once your child is in the bath, there can be no interruptions.
- Cover the bottom of the tub with nonslip mats or adhesive strips.
- Store cleaning supplies out of reach.
- The spigot can give a nasty bump to a little head. You can buy a spigot cover at a baby-supply store.
- If your child uses a bath seat, make sure it is secure.
- Hang a bath thermometer (from a baby store) on the tap. Before putting your child in the tub, check that the temperature is best for maintaining your child's proper muscle tone.
- Do a "dry run" first, to solve any unexpected problems.

How to prepare your child

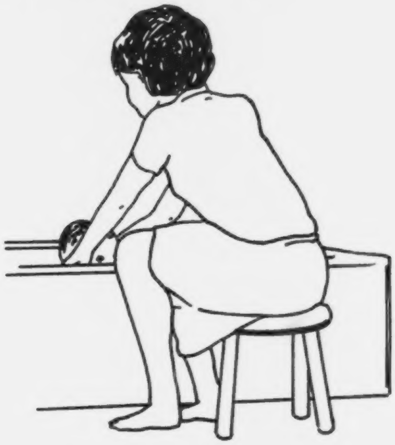
Undress your child in the bathroom so the preparations will become a familiar, reassuring routine. Talk about what you are doing and handle the child in a way that will best control muscle tone. A tight child may respond to slow, gentle rocking while being held in a very bent position. A floppy child may need to be tickled, rubbed, and patted to increase muscle tone.

Protect your back!

Ask your therapist if you're not sure how to lift with your legs.

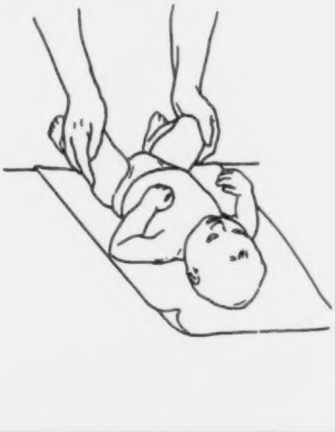
An extended shower hose makes shampooing easier. It controls splashes better, too.

Sit on a low stool beside the tub.



Washing tips

To open tightly closed legs, hold the child's thighs near the knees. Bend the hips and rotate the legs outward at the same time. Keep the knees open with your forearm as you wash with the other hand.



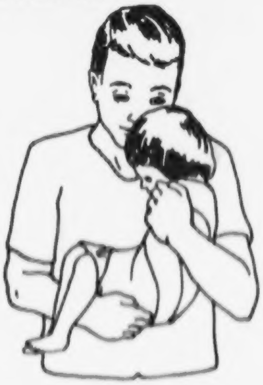
143

Try using warmer water if your child is sensitive to touches and splashes. Or put a T-shirt on the child, or wrap the child in a piece of sheet. Open the sheet to wash one part of the body and then close it again. Put a washcloth mitt on the child's hand and encourage self-washing.

Keep washing fun! Hang toys on strings across the tub, and stick suction toys to the sides. Have floating and sinking toys, toys to fill and squirt, and toys to pat and poke. Rub the child with different towels, brushes, or sponges to stimulate the skin and to increase body awareness.

Drying tips

To lift your child from the bath safely, first wrap the child in a towel. Bend the child tightly at hips and knees, hold the child close to your body, and use your legs to lift. Dry with firm pressure. Try a terry cloth robe or poncho if your child dislikes being touched. Talk and play as you dry your child—it's a good time for songs, games, and eye contact.



What special equipment is available?

Many bath aids are available at local department stores. Also, look through your therapist's catalogues of medical equipment.

Children grow quickly and their needs change. Before spending a lot of money, find out what works best. Try to borrow a seat before buying one, look for second-hand equipment, or locate a lending library.

Dental care

Dental care is very important for the child with cerebral palsy. Sensitive lips and gums, difficulty in positioning the child, and fear can all make the dentist's job difficult. Here are a few basic rules for good early dental care:

- Avoid sweet foods and drinks, or include them only in meals
- Avoid between-meal snacks
- Clean mouth and teeth after every meal
- Take your child to the dentist regularly

Preparing your child's mouth: To make your child's mouth less sensitive, stroke, pat, and tap the muscles around the mouth and massage the gums with your clean finger or mouth swab (from any drug store). Your therapist can show you what to do.

Brushing teeth: Position your child for good head control. Use a small, soft toothbrush, wet with water. Gently insert the brush at the side of the child's mouth, then brush the outside of the teeth and gums. Use circular motions. You might need to use jaw control to reach the inside surface of the teeth and gums. Your therapist will show you how.

When the child is familiar with brushing, put the toothbrush in your child's hand. Cover the hand with yours and brush together.

Spitting comes later. For a start, position yourself close to the sink with the child straddling your lap. Lean forward so that all water and saliva runs out of the child's mouth. To prevent gagging or choking, the child's mouth must be completely empty.

Eventually, introduce toothpaste. You might want to try an electric toothbrush, which massages the gums and cleans the teeth better.

Combing and brushing hair

Have your child in a good sitting position. To prepare your child, lean forward, then slowly stretch the arms out and up, palms facing inward. Hold the brush in the child's hand and your own and brush together. Encourage your child to look in the mirror if it's not too confusing.

To comb or brush hair without help, your child must be able to reach the top of the head with one hand. A good way to practice is to play "dress up" with funny hats, crowns, wigs, and necklaces. Use a beanbag or a small rubber ring for a crown and have your child swipe it off in a combing action.

If your child has trouble holding onto the brush or comb, buy combs with handles and pad the handles with tubing. Look for a brush with a strap that slips onto the palm, or make your own.

Washing hands

If your child has tight muscles, stretch the arms at the shoulders to reduce muscle tone. This prepares the child for activities which use the arms.

Sometimes it's difficult to wash inside a tight fist, even with preparation. Don't try to pry the fingers open. Instead, bend the wrist and turn the thumb gently upward. Then slide your thumb into the fist. Move your fingers slowly and wait for the child's fingers to open.

Preparing your child to wash hands without help: Most children can wash their hands by about age 3. To get close enough to the sink and for extra stability, your child may need a special chair or a footstool. If your child uses a wheelchair, remove the cabinet doors under the sink so the child can get closer. Cover exposed hot water pipes.

Keep soap, plug, washcloth or mitt, and towel near the sink. If picking up soap is hard for your child, slip a soap mitt onto the child's hand or hang a "soap on a rope" from the faucet.

Extended handles (from medical supply companies) will let your child reach faucets at the back of the sink. If your child lacks good standing balance, install a strap that goes under the child's bottom. Your child will feel safer leaning against the strap.

Games to help develop handwashing skills

- Child sits or stands at the sink and plays with sudsy water, clapping hands to make bubbles fly—and to pop them.
- Rolling play dough between the hands teaches the hand-washing movement.
- Putting fat pegs into a formboard is like putting the plug into the drain.
- Playing with toys that screw and unscrew helps develop the twisting movements the forearms and wrists must make to control the faucets.

Drying hands

Learning about hand drying will be easier if your child is aware of fingers and the backs of the hands, so the child needs to do lots of two-handed play. To practice, use crayon soap to draw "happy faces" and other patterns on the back of the child's hand. Then have the child wipe the pattern off with a toweling mitt. The game "Itsy, bitsy spider" is another good way to learn about hands.

Summary

At some point your child will want to do these activities without help. Keep the tasks fun, safe, and well organized—that's the best way to keep your child interested, cooperative, and successful.

For more information

Dunaway, A., and M. D. Klein. 1988. *Bathing techniques for children who have cerebral palsy.* Tucson, AZ: Therapy Skill Builders.

Finnie, N. R. 1974. *Handling the young cerebral palsy child at home.* New York: E. P. Dutton.

145

Toilet Training

by Avtar Dunaway, O.T.R.

Toileting doesn't have to be a struggle; success will come when your child is physically and emotionally ready. Toilet training is just another learning process and it takes time.

Read about several different toileting techniques and choose the one that seems best for you and your child. Don't set a rigid schedule—take one day at a time. Prepare your child by reading about toileting, acting as a role model, and having the child sit on the toilet. You will need special equipment to help your child sit on the toilet comfortably and safely.

Readiness

Your pediatrician can tell you when your child is physically ready for toilet training. One approach says that your child should be able to stay dry for two hours before you attempt toilet training.

Help your child recognize what urination and bowel movements feel like by giving your child words for what has just occurred. That will help your child learn to figure out and react to internal sensation. The toileting program you use should give details on what words to use and further readiness skills.

Support people

Many children with physical disabilities have problems with constipation and abdominal discomfort. Along with your pediatrician, here are several specialists who can help:

- A *nutritionist* can tell you what foods and fluids are best for your child.
- People who are certified through the *International Association of Infant Massage* can instruct you in abdominal massage. Many of their techniques help relieve stress, constipation, and abdominal muscle tension.
- Some *occupational* and *physical therapists* are trained in ways to move the trunk and lower body to change abdominal muscle tone.
- Some *registered nurses* and *nurse clinicians* who work with urologists train parents to handle catheters, implants that trigger bladder release, and other specialized medical devices.

Preparing your child

The toileting program you use should clearly outline how to prepare your child psychologically for toilet training. After your child knows what to expect, help the child become familiar with the potty you've chosen. To reduce your child's anxiety, stick to a toileting schedule and make sure the child is secure on the potty.

Toileting equipment

Your child's school should use the same program and equipment that you use at home. Work with your child's teacher and therapist, and your extended family, to choose toileting equipment.

Often, specially adapted equipment is necessary for secure positioning. Medical supply companies have catalogues of toileting equipment, and your therapist will also know about available equipment.

Most specialized toilet chairs are expensive, so try to borrow or rent a chair before you buy it. Some families have built their own toilet chairs or worked with therapists and medical supply companies to develop special chairs. Make sure that the chair fits your bathroom as well as your child's needs.

Choosing toileting equipment

Straps: Many toddler toilet chairs have straps to secure the child. Do not use the straps as restraints, and never leave the room when your child is strapped onto the toilet.

Most children who are mobile and can get in and out of the toilet chair by themselves will use it within five minutes of getting on the toilet. Some parents read to the child to help the child stay in one place for five minutes.

The more disabled the child is, usually the more straps are needed. The child may also need more time on the toilet—it may take ten minutes for the child to relax enough to actually use the potty.

Splash guards: Check the width and edges of the splash guard. Some guards can cut into the legs of a child who has cerebral palsy. Some toileting equipment comes with a permanent splash guard, which a girl may not need.

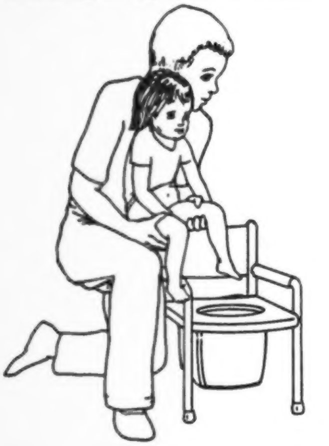
Cleaning: Try cleaning the equipment. Can you remove the pan easily from the base? Does it slide along the tracks smoothly? Can the equipment be removed so other family members can use the toilet?

Toileting for children with specific cerebral palsy symptoms

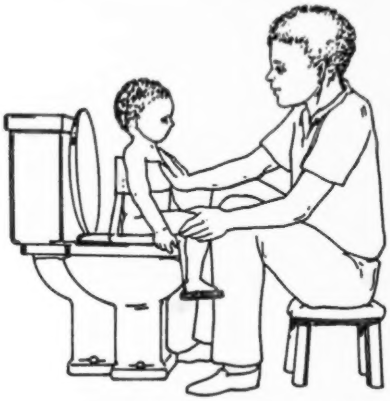
The child whose muscles are spastic needs a potty seat that keeps the hips securely back in the potty, supports the legs, and spreads the hips apart. Foot rests are recommended.

Quick movement and excitement tend to make muscles tighten. Use a quiet voice and slow movement as you move the child onto the potty seat. Help the child keep hips flexed and spread apart.

One way to move the child is to hold the child's back against your chest. Flex your child's hips by leaning your trunk forward. Keep the legs apart by holding a leg in each hand.



Some parents sit in front of the child while the child is sitting on the toilet. The parent then spreads the legs and rotates them outward.

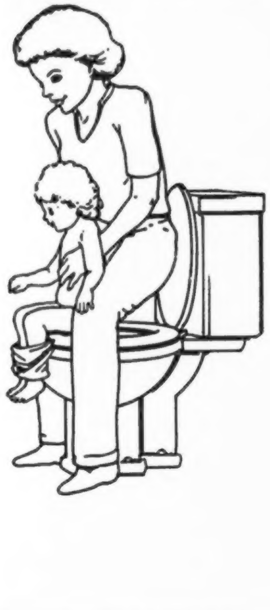


Make sure the deflectors don't dig into the insides of your child's legs.

The child whose muscles are hypotonic needs a potty with back trunk and hip support. Footrests stabilize the rest of the body. A potty lap tray will help with posture. Your child may need additional trunk and pelvic straps.

The child with low tone tends to slip out of your arms, and head and trunk control is difficult. The potty chair should give a stable base and sides to work from. When lifting the hypotonic child, keep the child slightly forward, legs bent together. Support the head and/or trunk as necessary.

You can use your own body as a toileting device. Sit on the back edge of the toilet and hold your child in front of you on the potty. That lets you support the child's trunk, keep the legs separated, and lean forward to flex the child's trunk.

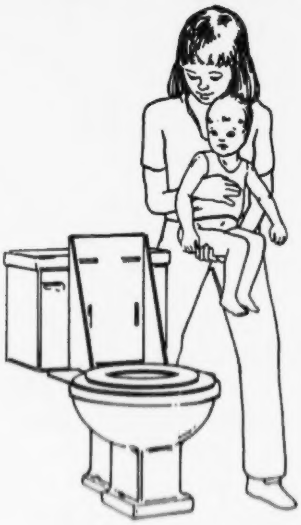


147

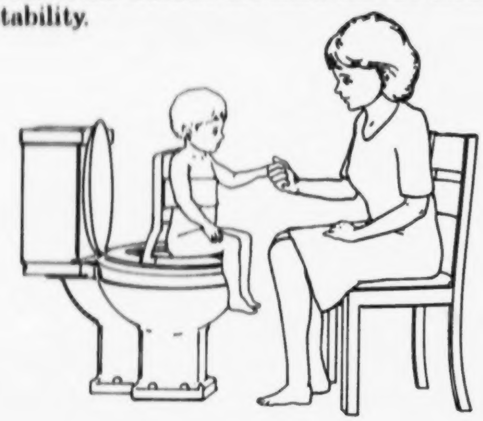
The child who has athetosis needs a potty with lateral support, back support, and hip support. The child does very well with supinator bars on the potty tray.

Athetosis makes controlling movement difficult. The child's movements are usually involuntary, making it very hard for the child to move into a position. The child needs firm, stable handling.

Keep the child well collected before moving to the toilet. Sometimes it helps to ask your child to achieve a quiet body before you lift. Move slowly when lifting. Hold the child slightly forward with legs bent and together. Try to keep the child's arms tucked in close to the body.



Some parents sit on the toilet behind the child so they can provide trunk support and control the child's movements. Other parents sit in front of the child so the child can use them for stability.

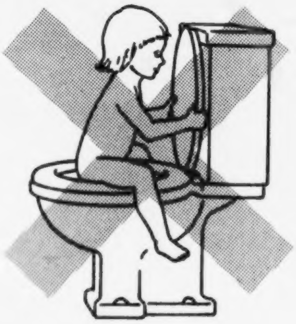


The child whose muscles are ataxic will have toileting needs that vary according to the degree of muscle tone.

Many children with ataxia find amazing ways to climb into and out of equipment. They often tip their potty chairs over as they try to crawl up and into them. To prevent tipping, use a potty with a wide base of support, or screw the legs of the potty chair to a large wooden base.

Some children need just a handrail or heavy chair in front of the potty chair. This lets them balance themselves while standing or pulling down their pants.

Warning: Some parents teach their children to sit facing the back of the toilet. This is dangerous, because the child can easily fall backwards onto the floor. The position is easy to get into, but hard to get out of safely.



Books about toilet training

There are many toileting books and programs available at the library. Your pediatrician, neurologist, or urologist can help you choose the one best for your child. It's important that you understand your child's development of bowel and bladder control, because toileting is such a vital part of independent living.

FEEDING

1: Choosing the Right Formula
2: Introducing Your Baby to Solid Food
3: Self-Feeding Readiness
4: Failure to Thrive
5: Switching from Tube Feeding to Oral Feeding
6: Your Child Has a Cleft Lip or Palate

Choosing the Right Formula

by Maria T. Nardella, M.A., R.D.

Breast milk is best for most newborns, but breast-feeding is not always possible. There are many good infant formulas; how can you choose the one that is best for your baby?

Federal law regulates infant formulas made in the United States and specifies the nutrients they must contain. Most formulas are very similar; most healthy, full-term infants will do as well on one formula as another. Choosing a formula may be as easy as picking the one that is most available and costs the least. But some babies are sensitive or allergic to the sugar, protein, or fat in certain formulas.

Some infants cannot digest lactose, the natural sugar found in both human and cow's milk. Soy formulas do not contain lactose, so they are a good substitute.

Other babies are allergic to the protein in both cow's milk and soy formulas. They would probably do well with a formula made from *hydrolyzed* protein, which is predigested and easier to absorb.

And other babies don't digest some formulas well because of the kind of fat used. Switching to a formula made with alternative vegetable oils would help.

Here are some of the common symptoms of formula sensitivity. Tell your doctor if your baby:

- Often has an upset stomach
- Spits up excessively
- Has frequent constipation
- Has continual diarrhea
- Has an unexplained rash
- Is excessively irritable
- Has poor weight gain
- Has frothy stools.

How can I tell if my baby has a food allergy?

After ten days, Anne weighed nearly a pound less than when she was born. She was a fussy baby who would settle down while she ate and would drink 4 ounces of formula at every feeding. But soon after, she would squirm and kick like she had a stomach ache. She'd have a lot of gas and loose, watery stools. Each day, she drank at least 24 ounces of a formula based on cow's milk.

At the two-week checkup, Anne's pediatrician thought she was not digesting the lactose in the formula and switched her to a soy formula. Within a day, Anne's cramps and gas stopped, her stools were firmer and less frequent, and she was much more content.

Are there other causes for the same symptoms?

Yes! Switch formulas only when no other cause can be found. Some other causes are:

- Improper formula mixing
- Poor feeding techniques
- Excessive amounts of formula
- Poor sanitation
- Physical problems such as abnormal muscle tone or a poor suck or swallow.

How could my feeding technique cause a problem?

A big baby, Carlos loved his bottle. He could suck down eight ounces of formula in less than five minutes. But he would soon burp up half of it. His parents thought Carlos was allergic to his formula. They switched brands, but the problem continued.

Finally, they took Carlos to the clinic and fed him while talking to the nutritionist, who saw that Carlos sucked so hard and fast that he swallowed a lot of air. When he burped, a large amount of formula came up, too. The nutritionist suggested giving Carlos smaller amounts of formula more often during the day, and burping him after every ounce. Soon he was sucking more slowly, swallowing less air, and wasting a lot less formula.

Most babies regulate how often and how much they need to eat—usually from 20 to 32 ounces a day. Others need help in getting the right amount of formula. Babies don't all need the same amount, but each baby needs enough formula to grow at a steady rate. If your baby can't drink enough formula to gain weight, your doctor or dietitian might add calories to the formula.

Why would improper mixing cause a problem?

> Kevin was a healthy but small baby. At age 3 months, he developed constipation—he was having difficult, dry stools only every other day. His mom thought that the powdered formula must be causing the problem, so she called the nurse at Kevin's doctor's office about changing formulas.
>
> The nurse learned that Kevin's mom was adding an extra scoop of dry formula to Kevin's bottles to help him grow bigger. Because he wasn't getting enough water, his stools were hard and dry. When his mom started mixing his formula the right way, Kevin began having easy, soft stools again and continued to grow at a rate that was right for him.

Why is a balanced diet important?

After about 6 months, milk or formula is still a primary food, but your baby needs nutrients from solids, too. To detect any allergies, introduce solid foods one at a time. Start with one to two teaspoons per meal and work up to three to four tablespoons. By age 1, your baby should be eating a variety of cereals, fruits, vegetables, meats, and some forms of bread.

> Laura's delivery was long and difficult. She couldn't breathe right away and the lack of oxygen caused brain damage. One result was that she couldn't swallow properly. Every time she ate, formula seeped into her lungs. She was hospitalized three times for pneumonia before she was 4 months old.
>
> Her parents and doctors decided that she needed another way to get food until she could learn to eat by mouth. Laura began receiving formula through a gastrostomy tube directly into her stomach, and her health and growth greatly improved. But, at nearly 2 years of age, Laura was still getting only infant formula. The amount had been steadily increased, so she was getting enough calories to keep gaining weight. But her growth in length had slowed down, and she was sick more often. Her dietitian realized that Laura needed a balanced diet—not just infant formula—through her tube.
>
> The family had a choice: switch to a tube-feeding formula with the extra nutrients an older child needs, or follow a recipe each day that combined infant formula or whole milk with blenderized foods.

When can my baby switch to whole milk?

Infants older than 6 months can drink whole milk if at least a third of their caloric intake comes from other foods. If you're not sure about your baby's total calorie intake, stay with formula for the first year. Then, gradually switch to whole milk.

> Michael was an 8-month-old who was consuming nearly 36 ounces of formula daily before solids were introduced. Now he drinks 24 ounces of whole milk with a variety of foods that often include half a cup of oatmeal and one jar each of strained meats, fruits, and vegetables.

Infants under age 2 should not get certain kinds of milk, because they don't contain the proper nutrients or may be health hazards. These include:

- Lowfat or skim milk
- Raw milk (either cow or goat)
- Unfortified goat's milk
- Imitation milks.

Tell your pediatrician or dietitian if your baby seems sensitive to infant formula. The formula may or may not be causing the problem—with so many formulas to choose from, getting professional guidance is the best way to deal quickly with your child's problem.

Introducing Your Baby to Solid Food

by Jeanne Koutz, O.T.R.

Most parents have lots of questions about introducing their baby to solid food. How old should the baby be? What food to give first? How much?

Here are some basic guidelines for this important step. Be sure to check first with your baby's doctor, in case your baby has special feeding needs.

When do I start?

Most pediatricians say to wait until the baby is 4 to 6 months old or 13 to 15 pounds. Starting solids too early can trigger food allergies. Also, before age 3 months, the mouth muscles and digestive system aren't developed enough to handle solid foods.

Is my baby ready for solid food?

Your baby should:

- Be able to hold the head upright. If the head falls backwards, put the baby in a *semi-reclined* position—sitting halfway up, with the head higher than the hips. Give support at the base of the neck, not at the back of the head.
- Touch, hold, and taste objects. Does the baby notice things or try to grab them? Does the baby bring hands and toys to the mouth? If not, gently bring hands to mouth. If you feel resistance, lay the baby on one side and try again. Place a soft toy in the baby's hand and bring it to the mouth.
- Move the tongue back and forth, instead of just pushing out. Encourage this tongue motion by placing a baby spoon inside the mouth on the tongue. Your baby's therapist can suggest a good spoon for your baby. Thicker *textured foods*—like applesauce or cooked vegetables that have been through a baby-food grinder—can also stimulate tongue action.
- Be able to seal the lips tightly around the bottle, so that less liquid dribbles down the sides of the mouth.

How do I start?

Start foods one at a time, a week apart. That way, if your baby has an allergic reaction—such as vomiting, diarrhea, or rash, you'll know which food to avoid.

What foods should I give first?

Cereals (Start at 3-4 months or 12 pounds): Single grains, such as rice, oats, or barley. At 7 to 9 months, try wheat, mixed cereal, or soft, creamy cooked cereals.

Vegetables (at 4½ months): Strained or pureed. Give vegetables before fruits to discourage a sweet tooth and the tendency to reject vegetables. Start with milder yellow or orange vegetables: squash, carrots, or sweet potatoes. Later, add green vegetables: peas, green beans, and spinach.

Fruit juice (at 4½ months): Dilute with water at first. Start with apple juice or pear or peach nectar. To prevent possible allergies, don't give citrus (orange juice, lemonade) for the first year. Avoid punch and soda. Don't add sugar to juice.

When should I give food?

Give solid food at the beginning of the meal, when your baby is most hungry. Give first cereal at the last feeding of the day; it might satisfy your baby through the night. When the baby is eating solids twice a day, try giving food at mid-morning and early evening. Solid food is only a supplement; breast milk or formula is still the main source of nutrition for the first 6 months.

How much food should I give to start?

Introduce each new food with one teaspoonful. Cereals can be thinned with two or three tablespoons of breast milk or formula. As baby gets older and lip and tongue control develop, increase the amount of food given, a teaspoonful at a time. Give less food at the next meal if your baby is taking less milk than your baby's doctor recommends for that age. By age 12 months, give no more than four tablespoons of each food.

How should I present the food?

Feed cereal from a spoon, not a bottle. This helps develop the tongue muscles and promotes clearer speech later on. Let your baby use the lips to remove food from the spoon, instead of scraping it off against the roof of the mouth. You can also bring the top lip down with the side of your finger to stimulate lip-muscle action.

What about later foods?

As your baby's chewing and digestion develop, give foods that are thicker and have more texture or lumps.

Meats (at 6 to 8 months): Strained or pureed, starting with one teaspoonful. Start with lamb, then poultry, veal, and finally beef. Instead of meat, you can give soft cooked beans.

Mashed table food (at 7 to 9 months): Cottage cheese and mashed potatoes. Mash cooked vegetables already in baby's diet with a fork. Finely chop canned fruits such as pears or peaches. Also give junior meats, cooked fish, and mild cheese.

Egg yolk—yellow part only (at 9 months): Buy this in the baby food section of the grocery store, or prepare it at home mashed and mixed with breast milk or formula. Egg whites can promote allergies, so don't give these for the first year.

Finger foods (at 9 months to 1 year): For teething, give hard/dry toast and graham crackers. Give soft cooked vegetables cut in strips or soft cooked pieces of fruit, and bite-sized pieces of soft-cooked meat, poultry, and fish. Noodles, macaroni, baked potatoes, scrambled eggs (at age 1) and chunks of tuna or cubes of cheese are great finger foods.

Finger foods to avoid: Do not give foods that can cause choking or get caught in the throat, such as popcorn, nuts, bacon, potato chips, hard candy, whole grapes, hot dogs cut in round pieces, celery, raw carrots, tough meats, or fish with bones. It's okay to give grapes cut in half and hot dogs cut in half *lengthwise.*

Foods to avoid for the first year

By age 1 it is safe to add foods that cause allergies. Avoid honey for the first year; it can cause infant botulism—a serious and often fatal food poisoning. Cooking does not kill the bacteria, so avoid muffins or cookies baked with honey. After one year, add cow's milk to the diet, if your pediatrician approves. Give yogurt once baby has adjusted to milk. Do not give egg whites (or whole eggs) or citrus during the first year.

How do I know baby can handle finger foods?

Your baby should be able to bite on food. At first, break off pieces of graham cracker as the baby holds the cracker tightly between the gums. Next, give a piece of soft cooked carrot. It's time for finger foods if the baby munches up and down.

When do I start using a cup?

The ability to sit up, with support, is a sign that your baby is ready to try a cup. At this point—about age 6 months—the lips form a seal on the bottle and the tongue no longer pushes forward.

Use a small plastic cup with a drinking spout on the lid. Give diluted juices daily. Start with a small amount and work up to six to eight ounces. As your baby learns to use the cup, give less breast milk or formula. Some pediatricians suggest weaning from the bottle at around 14 months.

When baby wants to eat without help

Between 6 and 10 months, your baby may try to grab the spoon from your hand. Let the baby hold a spoon while you use another spoon, or have the baby help you take the spoon to the mouth. To teach self-feeding, let your baby try the spoon at the end of the meal and finger-feed at snack time. By age 1 year, your baby will probably begin trying to eat with a spoon but will need your help in finishing the meal for the next three to twelve months.

Summary

By 12 months your baby will be able to hold a cup and drink without help and will be finger-feeding most family food.

If your baby chokes, gags frequently, or doesn't seem able to handle thicker foods, ask your baby's doctor to refer you to an occupational therapist or speech and language pathologist for a feeding evaluation. The therapist can help solve a particular problem so your baby can go on to the next stage of feeding development.

Self-Feeding Readiness

by Judith C. Vestal, M.A., O.T.R.

What is readiness and why is it important?

Skills are like building blocks—new skills are piled on top of older ones. Your child needs to master basic skills before learning new ones. By recognizing skills when they appear, you can give your child the right challenge at the right time.

Is my child ready to eat without help?

Your child's attitude toward meals shows if the child is ready to eat without help. Some children become excited at mealtime and want to take part. They:

- Enjoy playing in the food
- Lean forward, mouth open, to show they want the next bite
- Begin to prefer certain foods
- Reach for the food, the spoon, or the cup, and try to bring the utensil to their mouths.

Children with multiple disabilities may not be able to lean forward or reach out for food. But they may give more subtle clues, such as head-turning or changes in facial expressions. Foods they enjoy often seem easier to manage than others.

How can I help my child learn to self-feed?

To make learning to self-feed easier and less frustrating, plan ahead—a plastic mat or shower curtain under the chair will make clean-up much easier.

You first need to look at the stages of self-feeding. Here are the steps babies go through when they learn to feed themselves.

Learning to handle a bottle is the first step. Babies usually hold a bottle at about 5 to 6 months of age.

To use a bottle without help, your baby must be able to bring the hands together at the center of the body. A sidelying position is easiest, since the hands automatically come together in the middle so you can place the bottle between them.

There are several bottle holders on the market. The holders go over the bottle so the baby has two handles to hold. Or just hold your hands over the baby's hands, so the baby gets the experience of having hands on the bottle.

Finger feeding is the next step. Babies put everything in their mouths as they explore their world. By age 9 months, they can hold a cracker and feed themselves. Start to finger-feed when your baby no longer tends to bite down on things.

Now your baby can explore by putting fingers in the mouth. Dipping fingers in pudding or mashed potatoes is fun now. When your baby is ready to hold the food, a strip of beef jerky, lightly steamed green beans, or strips of soft toast are easier to manage than crispy cookies or crackers. Avoid foods that can cause choking, such as grapes, nuts, popcorn, or round pieces of hot dog.

Spoon feeding comes next. A baby first uses a spoon as a toy, and almost accidentally discovers that it can take food to the mouth. By age 2, most children use a spoon fairly well.

To use a spoon effectively, the baby must be seated securely. Leaning on the table may be easier for your child. For extra stability, hold the child's elbow and guide the arm and hand slightly.

Letting your child hold your hand while you take the spoon to the mouth also gives stability. Later, the child might hold the spoon handle while you guide the end of the spoon. And finally, the child can hold the spoon while you guide the child's hand.

Give as much help as your child needs, but reduce your support as the child learns the new skill.

What kind of utensils should I use?

Spoons: Spoons with shorter, more rounded handles are easier at first. Some spoons have curved handles that make it easy for the baby to reach the mouth with the bowl still upright. Also look at the depth of the bowl—it's easier to get the food off a spoon with a shallow bowl, but a deeper bowl makes it easier to keep the food on the spoon before it gets to the mouth.

Dishes: A dish with higher sides is easier to use, because the child can scoop against the side of the dish to put food on the spoon. A dish or bowl with a suction base will move around less.

Cups: Choose a cup that fits your child's mouth. The rim of the cup may be rolled and easier to bite, which helps the child hold it steady. It may be easier for your child to use a weighted cup or one with handles.

Some cups have lids to reduce spills. The lid may have a spout or holes in it to allow the liquid to flow. If your child sucks on the spout—as if it were a bottle—use a lid with no spout to encourage more mature drinking skills.

Thicker liquids are easier to manage, because they flow more slowly and are easier to feel in the mouth. Fruit nectars, milk shakes, cream soups, and blended fruits and vegetables may be easier than fruit juice, milk, or thin soups.

Should my child use a straw?

Sure! Straws are fun! And they let you control the liquid, too. When your child is first learning to drink from a straw, dip the straw in the liquid and put a finger over the top to hold the liquid in the straw. Put the other end of the straw in the child's mouth and slowly release the liquid.

Another way to control the liquid is to use a small squeeze bottle—a catsup or mustard container is ideal—and place a piece of clear plastic tubing through the hole.

When your child is ready to suck from the straw, put a cork or a large bead on the end of a straw to limit how much of the straw the child can put in the mouth. This also helps get the lips together, which makes sucking easier.

My child is visually impaired. What can I do to teach feeding skills?

Here are some extra techniques that may help your child:

- Beginning during early bottle feeding, help the child put both hands on the bottle. This teaches routine and a sense of being involved.
- Keep the place mat and utensils in one place to help your child identify the "eating place."
- To develop a sense of routine and sameness, always put utensils, napkin, dishes, etc., in the same place on the table.
- Help the child learn to identify foods by smell, temperature, and tastes.
- Show your child how to use a piece of bread to push food onto the spoon.
- Bowls or plates with higher sides also act as "food pushers." They also contain the food better.

Summary

There are many special utensils and feeding aids available. To choose the ones best for your child, you must know how ready your child is to eat without help. Watch your child's skills closely to see how ready your child is to take this important step toward independence.

For more information

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Failure to Thrive

by Sanford Newmark, M.D.

What is failure to thrive?

Failure to thrive is a medical term that describes a baby or child who is not growing as well as expected.

How can I tell if my baby has failure to thrive?

Your doctor will check your baby's height and weight during every well-baby visit and will put the measurements on a growth chart. The growth chart is a way to keep track of your child's growth and to compare your child's growth to that of other children of the same age.

Your doctor will be concerned if the growth chart shows that your baby has stopped gaining weight or is losing weight. If the growth problem becomes a regular pattern, your baby has failure to thrive.

The doctor will also calculate the *percentile* of your child's height and weight. This is a way of comparing your child's growth with that of other children of the same sex. A child in the 50th percentile for height is taller than half the children of the same age and sex, and shorter than half. A child whose weight is in the 95th percentile is heavier than 95 of 100 children of the same age and sex.

Aren't some children just smaller than others?

Yes. Some healthy children are quite small—that's why it's important to keep checking your baby's growth. If an 18-month-old is at the 5th percentile for weight but has been at the 5th percentile for the past year, there's no cause to worry.

But if a 6-month-old has gained only 5 ounces in two months and has dropped from the 25th to the 5th percentile, the doctor will want to find out why.

Height and weight are both important. If your baby is at the 10th percentile for height, the weight should be at about the 10th percentile. A baby should not be at the 95th percentile for height but only at the 5th percentile for weight.

What causes failure to thrive?

Failure to thrive has many different causes. Sometimes there are physical problems, such as chronic diarrhea, cerebral palsy, or recurrent pneumonia. This is called *organic failure to thrive.* But often there is no real physical cause—for some reason the baby is just not getting enough food. When no physical problem is found, it's called *non-organic failure to thrive.*

Why does my baby have failure to thrive?

To get a thorough medical history of your child, the doctor will ask you many questions, such as:

- What foods does your baby eat? How much?
- Does your baby vomit a lot or have frequent diarrhea, breathing problems, or other unusual symptoms?
- When did the baby learn to roll over, smile, sit, and walk? This will help determine if your baby's nervous system is developing on schedule.

It's important that you answer the questions accurately in order to help the doctor make the right diagnosis.

A complete physical examination is next. The doctor will look for clues that may help find the cause of the problem. Using the results of the history and physical, the doctor may order laboratory tests or x-rays.

Usually, though, tests help only when the history or physical exam have pointed to a specific physical problem. For example, if your baby has a chronic cough and the doctor hears abnormal sounds in the lungs, the doctor will probably order a chest x-ray. But if there is no history of coughing or breathing problems and the lung examination is normal, an x-ray will probably not help and will expose the baby to unnecessary radiation.

My baby has failure to thrive. What can be done?

Treatment depends on the cause of the failure to thrive. If it's caused by an illness or physical problem, the treatment will be to solve the physical problem. Sometimes the solution is simple—if there's a blockage in the digestive tract, surgically removing the blockage will correct the problem.

Sometimes, treatment is less direct. If your baby has a great deal of difficulty swallowing food because of severe cerebral palsy, solving the problem may take a lot of time and effort by occupational therapists, nutritionists, your doctor, and you.

If your baby has non-organic failure to thrive, the approach is different. The first question is: Exactly how much nutrition is your baby getting? You will need to keep a complete record of every single thing your child eats and drinks, usually for at least several days. Often your doctor will send this record to a nutritionist, who can figure out exactly how many calories and how much protein, fat, and carbohydrates your child is eating.

The answer is fairly simple if the nutritionist finds that your baby is not getting enough nutrition. Your doctor and the nutritionist will figure out what needs to be done to help your baby get enough food. Your baby may need more feedings, different foods, or special formulas or food supplements. To make sure things are going well, the doctor will follow your baby's growth very carefully.

But what if your baby is getting enough nutrition but is still not growing? Your baby may have to be hospitalized so the nurses and doctors can watch the baby 24 hours a day. They would keep complete records of what the baby eats and drinks, and the exact amount of your baby's stool, spit-up, and urine. They may do more specialized laboratory tests and procedures as well.

Is failure to thrive a problem for children with disabilities?

Failure to thrive is often a problem for children with disabilities. They are more likely to have growth problems, and there may be other problems as well. Children with chronic illnesses like heart disease or repeated pneumonia often need more nutrition than other children. Children with cerebral palsy or other coordination problems sometimes have a hard time sucking and swallowing and don't take in enough food.

It can be hard to tell if a child with a disability actually has failure to thrive. Some children are very small due to brain or central nervous system problems they've had since birth, and no amount of nutrition will speed up their growth.

Don't feel all alone—there's lots of help available.

Caring for a child with a disability can be very stressful and difficult, and the added burden of feeding problems can simply be too much to deal with by yourself. It often takes a group of people working together to solve the problem. The group may include a pediatrician, a nutritionist, a physical therapist, an occupational therapist, and a home health nurse.

When everyone works together, the problem can almost always be solved and your child can begin to grow again.

Switching from Tube Feeding to Oral Feeding

by Suzanne Evans Morris, Ph.D., CCC-Sp.

What skills does a child need to eat by mouth?

Learning to eat by mouth is not as simple as it seems. Many things help the infant gain this seemingly natural ability. An infant:

- Feels hunger and thirst
- Associates sucking and swallowing with reducing hunger
- Has smooth and rhythmical sucking movements
- Can easily move liquid or food from the front to the back of the mouth for a swallow
- Momentarily stops breathing, so as to not inhale liquids
- Holds just the right amount of muscular tension to make it easy to move the jaw, lips, and tongue for eating
- Can feel different temperatures, weights, and textures of food or liquid in the mouth. That helps the infant choose which movements to use to suck, chew, or swallow the mouthful.
- Becomes more able to understand and use sensory clues such as taste, smell, touch, and pressure when starting to eat lumpy foods.

Why is tube feeding necessary?

Premature babies. Premature newborns are often fed at first by a tube inserted into the nose or mouth because the movements needed to eat by mouth are not developed yet.

Digestion problems. Some children develop conditions which interfere with digestion. They can be fed with a special formula that goes directly into a blood vein, bypassing the digestive system.

Disabilities. Cerebral palsy and other developmental disabilities, accidents, and illnesses can all interfere with feeling and movement, making it hard to coordinate the muscles used for sucking and swallowing.

Children with this problem often have difficulty sucking and moving the liquid or food to the back of the mouth for swallowing. As it is swallowed, part of the liquid may move into the airway, causing the child to choke and draw the liquid into the lungs.

Other children can suck and swallow without choking, but their movements are slow and eating takes a long time. The child may use a great deal of energy eating and take in very few calories. Weight gain may be poor and the child may not be able to eat enough to be healthy and well nourished.

When will my child be ready for oral feeding?

Learning to eat by mouth will be easiest when your child is both physically and emotionally ready. The transition will be smoother when your child feels accepted, trusted, and supported by you and other important adults.

Many children who have been fed by tube have been very sick; they've needed lots of medical care and may have spent months in the hospital. Suctioning, feeding-tube insertion, and other experiences have convinced them that the mouth is unpleasant. They have not felt joy and pleasure with the mouth, and they often mistrust adults who try to put things in their mouths.

Mouth sensitivity often increases when the mouth is not used for eating. Touches to the face and mouth can be uncomfortable or even painful to the child. When a spoon or nipple reaches the mouth, the child may cry or fight.

There are many important steps to take before you introduce food. Begin as soon as your child is healthy enough to accept touch and movement—long before the child is ready to eat by mouth.

How can I prepare my child for oral feeding?

There are a number of approaches. Some work immediately for oral feeding; others treat oral feeding as part of a program to develop total mouth skills.

The second approach is often slower but gives a child the chance to develop more complete skills. Your child will use the mouth to discover and explore the environment, will enjoy tasting and feeling things with the mouth, and will make many sounds. This approach also respects the child's own timetable for making changes. When your child begins to eat by mouth, feeding patterns will be more normal and complete.

When oral feeding is the only goal, children often struggle and learn to eat with a great deal of effort. Their eating movements are awkward, making it hard later to learn more advanced skills. They are often fearful and unhappy around food, and they don't enjoy the meal or the person feeding them.

A total program includes many of the following components:

- Improving the child's head, neck, and trunk control, since body movement influences movement in the mouth.
- Improving the child's breathing ability. Breathing and feeding are closely related; difficult breathing or mucus in the throat makes it much harder to swallow.
- Improving the child's response to touch and movement. Touching and moving your child is one way to show your love and trust. Your child can develop a more normal reaction to touch and learn to trust you and other adults.
- Improving the child's ability to swallow saliva and small amounts of food or liquid. Your child must learn to swallow without sucking food into the lungs.
- Improving muscle tone and movement in the jaw, lips, cheeks, and tongue—all of which are directly involved in eating.
- Developing a slow, regular rhythm of mouth movements. This rhythm is the most basic element in the normal feeding pattern.
- Learning to explore with the tongue and lips. This lets the child learn to tell the difference between different shapes, weights, temperatures, and so on.
- Developing the ability to make many different sounds. Since the same body parts are used for talking and eating, work on sounds often improves feeding skills.
- Developing the ability to communicate. Your child needs to express thoughts and needs. There are other ways to communicate—such as pointing or gesturing—if the mouth movements for speech are difficult for your child. It's easier for everyone when adults understand all the ways your child can communicate.

My child is ready to eat by mouth. What now?

Make the switch slowly; respect your child's needs and abilities. Give tastes and small amounts of food or liquid to show that the mouth can be interesting. Gradually increase the amount as your child's sucking movements improve.

As long as tube feedings drip formula slowly into the stomach, your child will never learn to feel hungry or full. Knowing what a meal feels like in the stomach will help your child want to eat by mouth. When your child is ready, give larger amounts by tube, equal to three larger meals and two snacks a day. **This is the most important step in preparing your child to eat by mouth.**

Good nutrition will always be important for your child. It often takes time for children to switch to oral feeding; make sure your child continues to receive enough nutrition through the tube until able to eat by mouth alone.

How can I help my child?

Think of your child's tube as a friend. It allows your child to get needed nourishment while sucking and swallowing skills improve. It gives your child the time to learn to eat easily.

Believe that your child can learn to use the mouth in a new and different way. Welcome the small changes as your child learns that the mouth can be fun and pleasurable.

Don't force your child to eat. By refusing to eat, your child may be showing fear or the feeling that there are no choices. By pushing harder, you convince your child that you can't be trusted—or that, by refusing, the child is stronger than you are. Children must learn to trust themselves, their bodies, and the people who love them. They must be willing to reach out and take risks.

Work with a childhood feeding specialist to help your child learn better mouth skills.

For more information

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Your Child Has a Cleft Lip or Palate

by Marsha Dunn Klein, M.Ed., O.T.R.

What is a cleft lip and palate?

A cleft is a separation of parts of the mouth that usually join together early in pregnancy. A cleft lip is the separation of one or both sides of the upper lip. Sometimes the ridge of teeth is also separated.

A cleft palate is a separation in the roof of the mouth and nasal cavity. It can include the soft back part or the hard front part of the palate. Your child may have both a cleft lip and palate or either one separately. The cleft can involve one side of the lip or palate (a *unilateral* cleft) or both sides (a *bilateral* cleft).

Clefting is a common birth defect. It can be inherited or caused by environmental factors. Discuss these issues with your doctor for more details.

What can be done about my child's clefts?

Your child's clefts can be corrected surgically. Usually the lip will be fixed first—most doctors do lip surgery within three months of birth. Cleft-palate surgery is often done after 12 to 18 months, to give the child's mouth some extra time to grow.

Can my child eat by mouth?

Yes. Unless your doctor advises against it, your child can be orally fed an adequate diet. Feeding is easy for some infants and more difficult for others.

Most infants with clefts adapt their eating skills. Here are some things you can do to make bottle drinking, cup drinking, and spoon and finger feeding easier for your child.

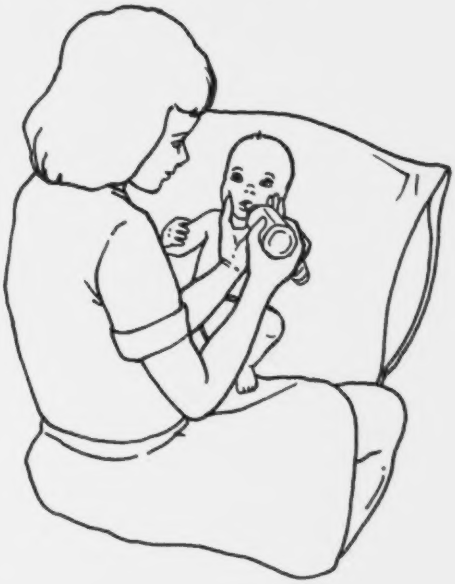
Breast Feeding

Though sometimes advised against it, some mothers are able to breast-feed their newborns. Your medical team can help you try to breastfeed, but your success will largely depend on how severe your child's condition is. Try holding your baby at an angle, with the head higher than the bottom. Gently hold the upper lip together at the cleft to help your baby achieve a stronger suction.

Bottle-Feeding

Babies usually have a strong desire to suck. Here are some pointers to help get the best results.

- As with breast-feeding, hold your baby's head higher than the bottom. This will help the baby swallow more directly and may help reduce coughing and choking.
- Use a nipple and bottle that let your baby suck easily and not get frustrated. If sucking is too hard, your hungry baby might become fussy and may fall asleep before getting enough food.
- Burp your baby regularly, since the clefts allow extra air to be sucked in. These air bubbles take up stomach space that should be used for food. They can also cause vomiting.
- Try holding your baby's cheeks forward to help create a stronger suck.



What type of nipple or bottle should I choose?

The nipple should be soft, allowing a flow that is easy but not so fast that your infant chokes or so slow as to be tiring. It should not be so big that it interferes with normal swallowing. Many people use soft preemie nipples or cross-cut juice nipples. Add extra pinholes or cuts to make commercially available soft nipples easier to suck. To give your baby some extra help, use a soft plastic bottle and squeeze it slightly.

Your medical team should have a variety of nipples and cleft-palate nursers for you to try. Work together to find the nipple and bottle combination that gives your baby the most pleasant mealtime experience and the best weight gain.

When and how do I start spoon feeding?

Introduce foods in the same amount and sequence you would with any infant. A cleft lip has probably been repaired by the time your baby is ready for strained foods and cereals, making it easier for the baby to close the lips and control food and liquid.

At first, offer small amounts of food on the spoon. Pause between mouthfuls, so your child has time to swallow. Let the child lean forward and open the mouth when ready for the next bite. Your child needs to feel in control of each bite while learning to direct food around the cleft and must trust you to slowly give bites that are small enough to handle.

The older child

Some children have problems with the formation of teeth and dental arches and may need an orthodontist to help with alignment. Speech can be difficult as the child learns to use the surgically repaired palate. A speech specialist can answer your questions about your child's speech.

Textured and table foods

Most children with cleft palates are given thicker textured foods, junior foods, or even soft table foods before their cleft is repaired. Sometimes it takes a while for a child to learn to direct the lumps away from the cleft. Go slowly—let your child practice with thicker foods and soft small lumps before trying more difficult foods.

When to see a specialist

It helps to discuss feeding with a specialist—your physician, a feeding specialist, or nurse—when the cleft diagnosis is first made. As your baby switches from bottle to strained foods, and then to textured and bite foods, further consultations and pointers can help.

Sometimes an infant continues to have problems with feeding. Poor coordination or problems with sensation and with movement in general can limit the infant's ability to allow for the cleft. See your doctor if you have questions about these issues.

For more information

Klein, M. D. 1988. *Feeding techniques for children who have cleft lip and palate.* Available through:
Therapy Skill Builders
P.O. Box 42050
Tucson, AZ 85733

The American Cleft Palate Education Foundation
331 Salk Hall
University of Pittsburgh
Pittsburgh, PA 15261

National Cleft Palate Association
Pam Birdwell, Secretary
RR #1
Buhler, KS 67522

March of Dimes, Birth Defects Division
1275 Mamaroneck Avenue
White Plains, NY 10605

Mead Johnson Company
Nutritional Division
Evansville, IN 47721

161

EMOTIONAL DEVELOPMENT

1: Normal Emotional Development
2: Emotional Development of Children with Disabilities
3: Being Aware of Your Child's Needs
4: Preventing Sleep Problems
5: Crying: What Does It Mean?
6: Anger in Children
7: Anxiety, Frustration, and Your Child's Behavior
8: Problem Behaviors: What Do They Mean?
9: Stereotypic Behaviors
10: Self-Injurious Behavior

Normal Emotional Development

by Margaret R. Dunlap, Ph.D.

Your child is growing—intellectually and emotionally as well as physically. Children develop at their own rates, but most follow a normal pattern of stages of emotional development. Here's what to expect during your child's first few years.

The infant

The newborn is completely helpless—your baby depends on you for everything. Building trust is the main emotional task now; if your baby's needs are always met, the baby learns that the world is a safe place and that you can be trusted.

But if your baby's needs are *not* met, no trust develops. This can cause many problems with later development, since each stage builds on the ones that came before.

At first, your baby has no sense that things continue to exist when they're no longer present. When you walk away and your smell, touch, and voice are gone, your baby has no idea that you still exist.

Body sensations dominate your baby's world—when hungry, wet, or cold, the baby is uncomfortable and cries. When you come to change the baby's diaper or give food, you take away the uncomfortable feeling. Gradually, the baby associates your voice and smell, and then your face, with pleasure and comfort.

Your baby learns to rely on you to feel safe and comfortable. As other people become recognized parts of the baby's world, your baby will trust them to provide these same feelings.

6 to 9 months

The baby begins to *discriminate*—to tell the difference between you and the bed, between you and a grandparent, and then between you and a stranger. Now your baby will begin to be cautious around strangers. Earlier, smiles have readily been met with smiles, and your baby would willingly be held by anyone.

Your baby is developing *object permanence*—the baby knows an object exists even when it's out of sight. The baby notices more about objects and people. This helps develop trust—if the important people in the baby's life keep coming back regularly, they can be relied on to provide for all needs.

During most of the first year, not much is expected of the baby. Babies cannot reason and have little control over their actions and their bodies. So we just accept them as they are, and get excited over every new accomplishment. This helps the baby develop a good sense of *self-worth*. As new skills develop, we cheer and brag, and the baby continues to feel safe and secure.

Babies are very sensitive to their surroundings. You are part of the surroundings, and your moods and actions affect your baby. When the routine changes, or you are rushed, the baby may become fretful, sleep less, or need to suck more. Usually the baby recovers quickly when the stress is removed.

At this age, words have little meaning. But you don't need words to give comfort and reassurance; your baby becomes very good at reading your body language, facial expressions, and even the tone of your voice.

The toddler

During the second year, your child begins to walk and to use words to communicate. Both skills give new control and independence. Your child can move quickly from one place to another and can see a whole new level of objects.

Security is still very important, but now your child's territory is expanding. Since you now exist even when you're out of sight, you can be left while your child explores the next room. But not for long! Your child needs to check in with you often, to make sure you are still there. Your toddler is developing *autonomy*—being able to do things alone. This is the major emotional task for this stage.

Your child begins to learn the names of objects and the power of words. The toddler will often give you an object after naming it. Words can even make you smile or give hugs. Your baby is learning how to influence other people and how to control the world.

That world grows bigger every day, but the toddler is still the center of it. Everyone sees and experiences things the same way the toddler does, your child assumes. Don't expect your child to share toys—or your attention—yet. Your child can focus on one activity, person, or object, but not for very long.

You need to begin setting limits for your toddler's behaviors, while encouraging exploration and autonomy. It's important at this stage to continue showing your child lots of *unconditional* love—just because the child is alive, not as a reward. This maintains the toddler's sense of trust while you teach which behaviors are acceptable.

At about 18 months, your baby will move into the "Terrible Twos" and begin to declare independence with words and actions. You may feel that "no" is the only word you ever hear. Your child seems to become more dependent and clinging than ever but often won't do what you've asked. This is a normal part of toddler development.

The preschooler

Starting with the third year, your child works on developing initiative and curiosity. Your child will imitate much of what is seen and heard and will try new behaviors to see how they feel and how people react. Preschoolers begin to be aware that they are part of relationships and especially triangles—with Mom, Dad, and themselves, or with a parent, sibling, and themselves. They are more willing to be part of groups. At first they will play beside, but not with, another child. The preschooler begins to share both toys and attention. Time begins to have meaning, so the child starts to wait for needs to be met.

Your child will begin to ask lots of questions, sometimes more as a way to get attention than to get an answer. Give your child both the answer and the attention. Along with the question-asking comes making comparisons—one way for the child to learn more about himself or herself. Your preschooler also begins to develop a conscience by learning rules and applying them in various situations.

The preschooler seems very independent at times, but you are still very important. You provide the emotional safety your child needs to risk taking the initiative and being curious. In these first few years, your child learns to "walk" emotionally—and then begins to walk away.

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Emotional Development of Children with Disabilities

by Daniel B. Overbeck, Ph.D.

If you're like most parents, you were not expecting or prepared for your child's physical or mental impairment. How you react to your child's condition is critically important to your child's emotional development.

There's a big difference between an impairment, a disability, and a handicap. A serious physical *impairment* such as blindness, deafness, or cerebral palsy will affect your child's development in predictable ways. The *disability* the impairment causes may be limited to only a small area of development. How you, your child, and other people cope with the disability largely determine how *handicapped* your child will actually be.

The effects of your child's impairment can vary widely, depending on whether the impairment is physical, mental, or a combination of both.

What can I do to help my child's emotional development?

You can do a lot. How you interact with your child affects the child's early emotional development and can support the healthiest development possible.

Most child development specialists agree that the course of emotional development is similar for all children, whether disabled or not. The pattern of development—the form it takes—may vary, depending on the child's experiences.

Your child's emotional development begins with the child's first meeting with the social and physical worlds. Your child learns through the senses—your touch, the sound of your voice, your facial expressions, and the feel of your body.

These *sensory* messages say that the child is lovable, is a source of pleasure and delight for others, and is valued. The messages help the child develop self-confidence and a good self-image.

Anything that interferes with the child's ability to receive those positive messages may alter the child's emotional development. For that reason, children with *acquired* impairments—those that develop after birth, such as from accidents or infections—often develop somewhat differently than do children with *congenital* impairments—those present at birth.

For the infant and the very young child, your response to the child and to the impairment is often more important than information from the child's own senses. A parent's message that a child is handicapped, vulnerable, helpless, or "a problem" can erase the child's natural optimism and pride.

What can I do on a day-to-day basis?

Every family is different. It's impossible to give detailed strategies to help all families, but here are some general suggestions.

Keep a balance between the fun activities you share with your child and the activities recommended by your child's therapists. Avoid working so much on therapies and training that your child loses you as a parent. Keep fun times simple—you don't need fancy or expensive toys or games. Focus on one-to-one contact with your child and on enjoying each other.

Set realistic, reasonable limits. Your pediatrician and other specialists can tell you what limits are or are not necessary. Learn to say "no" comfortably, even when your child reacts with a tantrum—it's important to not let your child use the impairment to tyrannize or terrorize people.

Don't try to make up for the impairment by giving in to your child's requests or demands. It can be painful to watch your child—who already faces more challenges than most other children—react to you with anger, hurt, or disappointment, but learning to accept realistic limits is essential to future emotional and social development.

Where can I find help?

There are resources in almost every community to help you support your child's healthy emotional development.

Evaluation services can help you understand the pattern and degree of your child's impairments and how those impairments might affect development. The best evaluation services describe your child's development to date and help guide future services.

Become informed about the problems that your child has or may develop. The public library and advocate groups such as the National Association for Retarded Citizens and the United Cerebral Palsy Foundation can help.

Many communities have parent support groups where you can meet and share emotional support with other parents who are coping with the same issues you are.

Counseling services can help you understand your reactions to your child's limitations and how those limitations affect your family, so that hidden emotions don't get between you and your child.

Summary

Your child's impairment means that your child will have to deal with issues and challenges that most children never face. How *you* deal with the impairment—and the attitude you pass on to your child—will play a big part in determining how much effect the impairment will have on the quality of your child's life.

Being Aware of Your Child's Needs

by Linki D. Peddy

As the parent of a child with disabilities, you probably deal with many professionals. They tell you how to exercise your child to improve sitting or walking, how to speak in different ways, how to give food, and how to play with toys.

It's important that you carry out the therapeutic plans and suggestions, but don't lose sight of the child in the process—your child's emotional needs are important, too. Here are some things to keep in mind.

Children feel better about themselves when they succeed.

Children build on successful experiences. To be positive and motivating, the experiences should satisfy a social and emotional need or goal for your child. Help your child learn to begin activities without your help and to use new skills in all areas of daily living. Ask yourself: "Am I doing this *for* my child or am I helping my child learn to take the initiative?"

Always getting a "honk" by pushing your nose teaches that your child can make things happen. Children learn to be passive when they are moved through activities without being emotionally involved—use your child's natural curiosity to make activities fun and interesting.

Many children with developmental delays need help to do their best as they learn new skills. Learning is done in steps—encourage your child to build on current skills. Keep your child's level of emotional development in mind and build on the child's strengths.

Be aware of how your child communicates.

Your baby may not have some of the tools most babies use to express joy. Is there a special look or gesture of pleasure unique to your child? It may be as subtle as a smile in the eyes.

You may also have to look to find how your child communicates discomfort or stress. Some children deal with increased stress by tensing their bodies. Others fall asleep.

> Your teenage son picks up his younger brother and swings him playfully. Uncomfortable with the quick movement, the younger child arches his back, brings back his arms, and makes his whole body stiff. The older brother understands and sets his brother down. The child relaxes and is more open to his older brother's next—slower—approach.

Encourage your child's feeling of being a separate person.

Your child needs to feel and express the full range of emotions, including closeness, pleasure, assertiveness, anger, protest, curiosity, and love.

Does your child have a hard time calming down without help? You might need to help the child develop this coping skill. Play simple games that emphasize each of the senses—hearing, touch, vision, taste, smell, muscle control, movement, and positioning—individually and in combinations. Be aware of your child's reactions. If your child is over- or under-sensitive, your therapist can suggest some activities to work with that sense.

Your child may need extra help finding positive outlets for frustration. A child who can't use the whole body to express emotion may need help developing alternatives. It's easier to give up an old habit if a better outlet is offered. Keep your responses clear and consistent.

> Your daughter bangs her head to express anger and frustration. She has no ear problems or other physical problems. Give alternatives: waving arms and legs, banging a toy hammer, or simple tumbling exercises. These will help her develop, as well as express her emotions.

Expect *just enough* from your child.

Adjust the way you respond as your child develops emotionally. Eventually, you'll be able to use words, expressions, and gestures to communicate without touching.

> Your 18-month-old daughter with motor delays rolls away from you and then looks back at you. Her pride is obvious. At this point, clapping, smiling, or saying encouraging words may be better suited to her development than a hug and kiss.

A child with disabilities faces special challenges in learning to be independent. The child may lack a sense of physical control and may have a hard time understanding things heard or seen from a distance. To build independence, help your child build on the things the child does well. At the same time, help the child feel secure in moving away from you.

> Your baby has some visual and motor impairments, and uses his other senses to explore his world. He stays in physical contact with familiar people at all times. It's important for him to start movements where he's not in contact with you.
>
> Begin by playing together on the floor. Use a toy which appeals to your child's stronger senses—maybe a toy that makes a noise when pushed or squeezed. After a few minutes he becomes interested in working the toy to get the response. Begin to put the toys nearby, without moving too far away. Constantly talk to him about the activity. Do this a number of times, as you gradually move farther away. Soon your child will be comfortable playing and exploring new activities by himself while you stay in verbal contact.
>
> Next, begin placing favored toys just out of his reach. A brother or sister can work the toy to catch his interest. Encourage him to move toward the toy. Be patient. Gradually move the toy farther away. Stay in verbal contact, be available when needed, and encourage your child's growing independence.
>
> Begin to experiment with leaving the room, but be sure to tell your child before you leave. Stay in verbal contact. Gradually he will begin to tolerate separation and do more on his own.

Interact with your child when you work together.

You can do many developmental activities as part of your daily routine instead of scheduling "therapy time" for them. Many stretching and range-of-motion activities can be done during diapering or "cuddle" time. Identifying body parts is a natural part of bath time. You should both enjoy your time together.

> To help your daughter increase her head control and her ability to bear weight on her shoulders and arms, you put her on her tummy over a rolled towel roll or bolster, with her arms forward. You know how important it is for her to develop a loving and caring relationship with you, so you sit facing each other.
>
> Together, do an activity that teaches cause and effect—you might say "honk" when she reaches to touch your nose, or smile and say "hello!" when she lifts her head and makes eye contact with you. Through many small steps, you can help your child learn a movement pattern.

Summary

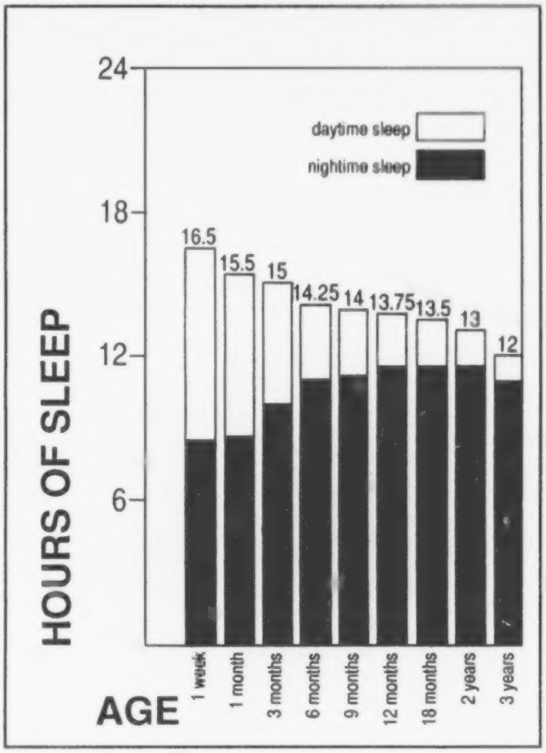
Every child can learn to relate to others and to have some influence in the world. Every child needs to develop positive self-esteem and a sense of being somebody. Your challenge is to provide learning opportunities for your child—to build on your child's unique set of differences and strengths, and to help your child live up to every bit of potential.

Preventing Sleep Problems

by Michael Cohen, M.D.

Many children have some sleep difficulty during the first four years of life. Beginning in the first few weeks of life, you can plan your child's sleep to avoid many problems.

Not every child needs to sleep the same amount. This chart shows the typical amount of sleep most babies and children need. Your child may differ from these averages by as much as four to five hours in either direction.



How can I start my baby off with good sleep habits?

Young babies—to about 4 months old—cry because of physical need. They can't be "spoiled" at this age, so when your baby cries, pick the baby up and give comfort by rocking and cuddling.

Your baby's sleep goes through great changes every night. Familiar sounds or nearby people or activity will wake a lightly sleeping baby, so try to have your baby sleep in a quiet, dark place. If your baby sleeps in a bassinet or cradle in your bedroom, have some kind of barrier between your bed and the baby during sleep time.

Babies tend to wake up more often when they sleep in their parents' bedrooms for a long time, so move your baby to another room as soon as you can.

You probably soothe and relax your young infant to sleep, but the older baby must learn to relax and fall asleep without help. If your baby can't go to sleep alone, it's not surprising that the baby can't fall asleep again after waking up at night. After the rituals of bathing, quiet play, and feeding, put your older baby into the crib while the baby is still awake. Your baby will become better at relaxing and drifting off to sleep without help.

When your young infant wakes up at night, take care of the baby quickly and matter-of-factly, without a lot of social contact or play. Then put the baby back in the crib and leave the room, to discourage waking up for the rewards of play and attention.

Many babies wake up at night for the privilege of sleeping in the parents' bed. This desire often continues throughout childhood. Avoid this attractive response to nighttime waking at all costs. It's difficult to make rational decisions at 3:00 a.m., but taking the easy way out—by taking the baby into your bed—will make it much harder for you in the long run. If your baby has been sleeping in your bed because of special circumstances—an illness, overnight company, or staying in a hotel room—stop the practice as soon as things are back to normal.

If your baby whimpers or cries lightly at night, wait a few minutes to see if this is only a light stage of sleep. Your young baby needs attention if the whimpering and light crying turns into heavier crying, which is not likely to stop on its own. Don't let an infant under 5 or 6 months old "cry it out." If the crying is out of control, try to soothe and relax the baby back to sleep—without feeding, if possible.

What about naps?

Avoiding long daytime naps can help your baby sleep better at night. How long your baby should nap depends on the baby's age. Infants should probably sleep at least four hours; most toddlers need no more than a two- or two-and-a-half-hour nap. If your baby sleeps well at night, the naps can be as long as the baby needs. But if sleep problems occur at night, cut back on daytime sleep.

How can I help my older baby sleep better?

At about age 6 months, introduce a "crib companion." Help your baby bond with a teddy bear or other soft object; the presence of the "friend" in the crib at night can be comforting.

As your baby approaches age 1, begin a pleasant, predictable bedtime ritual which leads to putting the baby in the crib at a set time each evening. This period should be quiet, without much stimulation. After the child is bathed and dressed for bed, play with a stuffed animal, read a book, or just talk. Sharing quiet time can help your child relax and get ready for sleep. Give the last feeding of the day before you put the baby in the crib.

This ritual should be a scheduled, everyday event as your baby gets older and moves into the toddler and preschool years. Change play activities according to the child's age and developmental needs. When your child is past infancy, make it clear that the child must stay in bed all night.

Don't postpone bedtime in the hope that a tired child will be easier to put to bed. When an over-tired child loses self-control, it can be almost impossible to meet the child's needs and the child can't fall asleep comfortably. Maintain a regular bedtime that is appropriate for your child's age.

Does your older preschooler resist going to sleep? Try allowing the child to stay awake—but only in the bedroom—as long as the child wants. Your child feels somewhat in control, while you maintain a defined bedroom time. There's little reason to stay awake once the child realizes that further contact with the family is unlikely, and the child is likely to drift off to sleep—perhaps while playing on the floor. In time, the child will find that a soft bed is a better place to spend the night.

My child is not sleeping. What should I do now?

You can start to use these suggestions at any time. You may need to adapt them for your child—every child is unique, and your child might not respond the same way other children do.

Sleep problems which you can't correct within two or three months probably will not stop on their own. If your child's sleep problems are stubborn, get help from a child development and behavior specialist.

The child with special needs

Children with special needs are sometimes prone to sleep problems. Children with neurological difficulties often have irregular sleep habits. Some children with disabilities are not stimulated enough during the day; they sleep too much and don't use up enough energy, so they aren't tired at bedtime. To make the nights easier, try to keep your child active and busy during the day.

Drugs can also affect your child's sleep. Antihistamines, decongestants, asthma medicines, and anti-seizure medicines can cause or add to a sleep problem. Drugs to help your child sleep should be used cautiously—they can make the situation worse, upset normal sleep cycles, or be addicting.

Poor sleep habits are a unique and very stubborn characteristic for a few children with special needs. When you've made all reasonable efforts, know that you've done your best. Adapting to the situation may be the only answer.

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Crying: What Does It Mean?

by Michael Cohen, M.D.

A crying baby is hard on everybody. Everything you do seems to be a waste of time—or makes the situation worse. You're exhausted, anxious, and frustrated. You're under a lot of stress, and maybe you even begin to question your abilities as a parent. You wonder why you ever decided to take on the job. Understanding why babies cry might make things a little easier.

Is crying normal?

Yes! All healthy infants, babies, and children cry. The amount and intensity of crying usually increases until about age 6 weeks, then decreases again, leveling off at about age 4 months. Most babies and young infants cry more in the late afternoon and early evening.

There is no "best" way to manage a crying baby. Some babies are calm and relaxed; others are very responsive. Some are usually positive; others are often negative. Some resist new experiences; others adapt easily to new sensations. About one baby in ten is "difficult." These babies are likely to be the hardest criers and cause parents the most anguish.

What makes my infant cry?

Your baby is trying to tell you something. All cries sound the same at first, but you'll soon learn your baby's specific cries for "hungry," "tired," "cold," and "wet." As you begin to get clues about what the various cries mean, respond in that specific way. If your response satisfies the baby, you've learned something. If not, try something else.

You can't "spoil" a baby by responding every time the baby cries. In fact, it's impossible to spoil babies younger than 3 or 4 months old. Each cry represents a real need.

Babies whose cries are answered immediately—by being carried or having a need met—are likely to cry less than other babies as they get older. This is especially true if the baby is also carried at least three hours a day when not crying.

Don't worry that your baby will learn to cry for attention. Some babies simply enjoy the "contact comfort" of physical contact. By crying to be held, your baby may be asking for physical comfort as much as for attention. Some babies howl when they are undressed because they miss the contact comfort of clothing.

If playing with your baby results in more crying, the baby might have another need. Is the baby wet? Hungry? Tired?

What is colic?

Colic is a common reason for crying. About 20 percent of all babies will have infantile colic. Colicky babies usually appear to have an upset stomach. They cry, draw up their legs, and have an excess amount of gas. Once the spell is over, the baby usually goes to sleep without difficulty.

Colic is most often a problem in the late afternoon and early evening. During other times of the day and night, the baby is usually relatively quiet, relaxed, and satisfied.

Babies with colic may have an immature intestinal tract, which overreacts and spasms in response to food, swallowed air, and sensations from the baby's environment. Other causes of colic include improper feeding, allergy, and difficult temperaments.

Parents have often been blamed—wrongly—for their baby's colic. Colic can be a baby's response to tense and anxious parents, but parental anxiety is often the *result* of colic, not the cause.

My baby has colic. What can I do?

- Hold your baby over your shoulder or across your knees; gentle pressure on the abdomen often relieves discomfort.
- Put a rolled-up baby blanket or warm water bottle under the baby's tummy at bedtime.
- Distracting, monotonous sounds—such as soft music, the sound of a vacuum cleaner, or the ticking of a loud clock or metronome— often help.
- Motion relaxes some babies. Try a ride in the car or a wind-up baby swing.

- Feed and burp your baby carefully to control the air your baby swallows.
- Diluted tea is sometimes helpful.
- To release uncomfortable gas bubbles, use a thermometer or suppository to stimulate a bowel movement.
- If other measures haven't helped, removing cow's milk from the mother's diet may help breast-fed babies with severe colic.
- Ask your doctor if an over-the-counter drug to break up the gas bubbles in the large intestine might help your baby. Because of possible side effects, other medications are rarely used for colic.

Infantile colic goes away by itself, usually at about 3 months of age. Other medical conditions can cause colic-like symptoms; see your doctor if symptoms are stubborn and severe.

What about older babies?

Babies older than 6 months often cry to express desires beyond simple physical needs. Now, responding too much *can* encourage crying for attention. Help your baby play and pay attention to things as ways to satisfy needs without your help. Still give lots of love and contact—but on *your* schedule.

Some babies start to fear typical household sounds, even those which have always been present. The vacuum cleaner, washer, dryer, or even the doorbell can provoke instant crying. Some babies cry in response to the unexpected, such as a different person giving food, a new sleeping situation, or seeing new people. Don't avoid these experiences, but, if your baby is easily alarmed, limit them when you can.

Older babies and young toddlers may cry because they feel helpless. Your child wants to follow when you leave a room but lacks the physical skills to do so. Crying is the natural response. Put stimulating objects within the baby's reach when you leave the room. A walker might allow your baby more mobility. The walker should be well built, and wider at the bottom than the top so it can't tip over.

What are the "terrible twos?"

Between about 6 months and 18 months, crying is reduced and is somewhat predictable. But the calm won't last; the stage known as the "terrible twos"—which actually begins at about 18 months—is a time of much more crying and even temper tantrums.

The terrible twos occur in all children, to some extent. Babies who have always had their needs met believe that they control the world. When you begin to set limits by saying "no" and making demands, your child resists with tears and tantrums. Not having control over objects is another frustration for your child.

How can I survive the terrible twos?

Regularly let your toddler know what you expect, and reward appropriate behavior. You can't teach your toddler self-control; all you can do is create the circumstances for the child to learn it and reward it when it occurs.

There are a variety of "time-out" routines that can help a youngster develop self-control and may even reduce the number and severity of tantrums. By spending a little time in a quiet place, your child can calm down, regain self-control, and then be rewarded for the self-control.

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Anger in Children

by Margaret R. Dunlap, Ph.D.

Feeling angry is just as normal as feeling happy or sad. It shows that we are connected to the people around us and that we care about things. You can help your child learn to recognize anger and express it in appropriate ways.

Why does a child get angry?

Anger is often **a reaction to physical or emotional pain**—an attempt to get rid of the hurt. When left with a baby-sitter, your child may feel lost and alone, or even unwanted. Those feelings hurt, and anger may cover the pain. Your child may sound angry when you put medicine on a cut, or when you move a stiff arm in physical therapy. The message is: "Why do I hurt?"

Children often get angry **when they don't feel in control.** Maybe your child's hands won't paint a picture the right way, or they knock down the stack of blocks before it's finished. Bad weather might force a change in family plans. Children also get angry if they can't control someone else's actions—this often leads to fights between siblings, or anger toward you.

Lack of control often leaves a young child feeling **scared**—a very uncomfortable feeling that can lead to anger. The child is angry both at feeling scared and at feeling uncomfortable.

Your child may react angrily when **tired or frustrated.** Again, the discomfort can lead to anger.

We all feel these "triggers" for anger, but they may be exaggerated for the child who has a disability. Often, a child with a physical disability has to work extremely hard to control movement to communicate. That makes feeling out of control—and angry—more likely.

How do children show their anger?

Children usually use behaviors they have already mastered to show their pain. A baby cries to communicate, but uses a special cry that parents soon learn means: "I'm angry!" Before starting to talk, your child may show anger by throwing something, kicking, or running away. When your child begins to use words to express anger, the message will usually be hidden. Instead of saying: "I'm mad," your child might say: "I hate you" or, "You're mean."

Other ways children show their anger are not as obvious. Your child becomes stubborn and quietly refuses to do what you ask. Maybe the child just "forgets" or doesn't do what you asked.

Other children turn their anger inward, becoming sullen or apathetic. They lose interest in activities, and their eating patterns change. These children are depressed. They've learned not to let others see their anger, but they still feel it.

Some children show their anger through their bodies. They may have frequent headaches or stomachaches. They may even get sick more often than other children, but usually there is nothing that the doctor can call a disease.

How should I react to my child's anger?

Your child has a right to have "good" and "bad" feelings. But your child also needs to learn how to cope with those feelings. You can teach coping methods by the way you express your own anger and by telling and showing your child other ways to act.

It is important to separate behaviors (what the child *does*) from feelings (what the child *feels*). Martha may be angry at Sam because he won't play with her, but breaking his truck is not a good way to deal with her anger.

Let your child know that you *recognize the feelings.* Name the feeling, so your child learns what to call it. When Julio says he hates Rebecca, you might say: "It sounds like you're really angry with Rebecca." Julio learns to name his feeling and that it's okay to feel angry.

It can help to sit next to your child, or get to the same eye level. Stay calm; that helps your child become calmer and demonstrates helpful behavior. If you are angry, too, tell your child, but show restraint. Your child will imitate what you *do* more than what you *say*!

Once you have shown that you recognize what your child is feeling, you can *act* in several different ways. If your child is old enough to explain what happened, talk about it. Don't judge your child; avoid statements such as "you should have" or "why did you?"

Try to find out what the anger is saying and respond to the message, rather than the anger. Does your child need help in stacking the blocks? Do the children need a system for taking turns? If your child is quite young, shift the child's attention to something more pleasant. Sometimes being held and cuddled helps ease the pain. If you can't do anything about the cause of the anger, help your child find acceptable ways to deal with the feelings.

What can my child do with anger?

Decide which behaviors are acceptable and then help your child use them to let go of the anger.

Crying may be the best outlet for the very young child—and sometimes for the older child, too. Allow it, but don't let the anger and tears control you. Let your child know that you are aware of the anger and that crying is okay, but that you will still do whatever you need to do. When the tears are gone, give your child a hug or some special attention—not to make up for the anger or because now the child is "nice," but just because you love your child.

The child may need some physical outlet for the anger. Squeezing a soft ball or a sponge, or banging the ball on a hard surface may help. Playing a drum or cymbals or hitting a pillow onto the bed or couch can relieve the need to hit.

Sometimes it helps to use the whole body: jumping in a swimming pool or on a trampoline, swinging hard on a swing, running around the yard, or even dancing.

If your child's movements are limited, try making pictures of the feelings with crayons or finger paints. Pudding and shaving cream make wonderful "paints," too. Dip a sponge into watercolor and pound it on paper, or use a potato cut in half.

Try some target practice with things that are safe to throw. Throw sponges or soft beanbags toward a wastebasket, or attach a paper target to a pillow. As your child becomes less angry, lead toward more positive feelings by making accuracy part of the game.

Sometimes your child needs to act anger out. Puppets, dolls, and stuffed animals can be the actors. Don't worry if your child doesn't use words—the actions are the most important part. If your child wants to tell a story, you may want to guide the play toward a new ending. Sometimes you can play the "enemy" and tell the "other side," or suggest another way to solve the problem.

Summary

Having angry feelings is a normal, healthy part of life. You can teach your child acceptable ways to deal with anger. Children with disabilities often feel angry because of pain, frustration, and lack of control. They have the same right as all people to feel angry and the same need to learn helpful ways of dealing with that anger.

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Anxiety, Frustration, and Your Child's Behavior

by Daniel B. Overbeck, Ph.D.

What is anxiety?

Anxiety is an uneasy, apprehensive, or fearful emotional state that is not related to a specific thing or event. Anxiety can be a chronic—long-lasting—condition, or it can be episodic—occurring only occasionally. It can disrupt your child's behavior in many ways. Anxiety which goes on too long can have serious health consequences, too.

> Margaret is a 5-year-old girl who has cerebral palsy. She was a happy, perky little girl, but then she changed. Now she has a hard time falling asleep at night. Most nights, nightmares and "scary things" wake her up. Her healthy appetite vanished; now the dinner table is a battleground as her parents try to coax her to eat a little more.
>
> Margaret used to urge her parents to go places and do things. Now she cries and withdraws when the family starts to leave the house or when she is left at school. The big smile that charmed friends and strangers is gone, replaced by a pinched look and lips that are pressed tightly together.

What is frustration?

Frustration is an emotional state caused by an unsolved problem or unfilled need. Most children and adults are frustrated every day; the increasing ability to deal with frustration is one sign of growing up. A child who shows occasional frustration is probably growing and developing normally. During "the terrible twos," a child learns to manage frustrations within family and social limits. But a child who always seems to be frustrated may need help.

> Inez is a 2-year-old girl who is blind. She screams and bumps her head on the floor when she doesn't immediately get what she wants. Bobby, a 5-year-old boy who is deaf, has a tantrum in the store when he can't have the candy bar he wants. Misty, a 13-year-old girl who is mildly retarded, sulks in her room because the family can't go to the movies.

As they grow, most children use increasingly verbal ways to deal with frustration.

> Jimmy, a 3-year-old boy with mild cerebral palsy, looks angry and says "I hate you!" A year ago, he would have thrown a tantrum. When Misty is 15, she'll probably accept the fact that the family cannot go to the movies. Instead of pouting, she'll tell herself that maybe they can go another day.

What can I do when my child is anxious or frustrated?

Some anxiety or frustration is a normal part of growing up. Situations that cause anxiety or frustration can be positive experiences, because the child learns to deal with the unpleasant feeling. Let your child try to work through challenging situations without your help.

When your child is anxious or frustrated, it may be enough to let the child know that you see the unhappiness and that your help is available—if it is wanted. If the source of the problem can't be identified or corrected, just "being there" can be reassuring.

To help your child cope more effectively with anxiety and frustration, encourage the child to identify the source of the feeling. A child younger than age 3 probably can't identify the source of *anxiety*, but may be able to let you know what is causing *frustration*. Give help, if needed.

> When Bobby's tantrum is over and he is again willing to look at his mother, she signs to him: "You wanted the candy. Mom said 'No,' and you were unhappy." Her comments won't help Bobby respond better to frustration right away. But, over time, he will learn *why* he feels so upset. That will help him find ways to express his feelings and cope with his emotions that are easier on himself and his family. If his mother had refused his request but then given in once the tantrum began, she would have taught him that a tantrum is a good way to get what he wants.

Deciding why your child is *anxious* can be more difficult. Ask yourself some questions:

- What has been happening with the child and the family?
- Has there been a death in the family?
- Have family relationships changed?
- Did the family move recently, or did the child overhear parental discussions of moving?
- Did the anxiety begin at the same time as a visit to the doctor, dentist, or other health specialist?

If you can't identify a reason for your child's anxiety, a child development specialist might be able to help. Provide copies of any evaluations, reports, or progress records you have regarding your child. After thoroughly interviewing you and other family members, the specialist may be able to suggest possible reasons for the anxiety.

If the source of the anxiety isn't found during the interview, the specialist may recommend a brief series of play therapy sessions. The sessions are a way to examine the child's free play patterns, which often clearly reflect the child's emotions and concerns.

Summary

Some anxiety and frustration is normal for all children. If problems persist, try to find and deal with the cause of the problem. If you can't identify why your child is anxious or frustrated, contact your local agency that serves infants and preschool-aged children with disabilities. The agency can give you names of child development specialists who may be able to help.

Problem Behaviors: What Do They Mean?

by Sharon Hendrickson-Pfeil, M.S., M.A., CCC

Children's behavior often frustrates adults. They seem to know just what "pushes our buttons"—how to get us irritated or angry and even how to hurt our feelings.

Why do children do that? What do they get out of such behaviors besides being nagged, scolded, or spanked? It doesn't seem to make sense.

But negative behaviors always have a "payoff." When we know what the payoff is, we know more about *why* the child behaves that way. Then we can meet the child's needs in a way that will encourage more responsible behaviors.

Why do children with disabilities often have behavior problems?

A child with physical or learning disabilities or developmental delays may feel discouraged by school subjects or everyday activities. It's tempting to offer unneeded help in feeding, dressing, or other self-care. But too much help sends the child a clear message: "You can't do it. I'm going to do it for you."

Real difficulties and excessive help can both discourage the child and lead to problem behaviors. Some children who don't expect to succeed as independent learners learn instead to enjoy keeping adults busy helping them, or defeated by tantrums. Others simply give up.

Children may tell us about their feelings through the behaviors they most often choose. Your child can seldom explain the reasons for tantrums, whining, or withdrawal, but you can usually identify the goal by paying attention to your own feelings as you respond.

Here are four common goals for problem behaviors, and ways to deal with them.

Attention-getting

Clues

"Mommy, come *HERE*!" "*HELP* me, Daddy!"

The child who constantly seeks attention has not yet learned to enjoy play or learning for its own sake. For this child, adult attention becomes the payoff. If you are the target of this behavior, you will probably feel *irritated.*

What to do

Ignore the child's attempts to keep you busy and to get your attention. Instead, give your child attention when it is least expected. Encourage your child when no attention-getting efforts have taken place. Try looking at art work, playing a game together, or giving your child a hug.

Power

Clues

"No, I won't!" "You can't make me!"

A child who is constantly in a tug-of-war and throws tantrums is out to get power. Some of this is natural during the early preschool years, and some children choose this goal more often than others. This behavior can leave you *angry,* perhaps to the point of yelling, spanking, or other rough, abrupt behavior. But remember: The power is the payoff.

What to do

- Withdraw from the power struggle.
- Offer alternatives; let your child choose.
- Use time-out strategies to remove your child's payoff. Send your child to a "time-out" chair or other area for a brief period of time—usually no longer than 5 to 10 minutes. Don't yell, nag, give long explanations, plead, or do anything else that encourages your child to continue the power struggle.
- Get together with your child's teacher to develop a program that works with your child.

Revenge

Clues

"I hate you, Mommy!" "I don't love you anymore."

The child who is after revenge wants to make the adult feel as hurt as the child does. The child knows that you very much want a hug or a greeting and will deliberately ignore you, going to someone else instead. Your own *pain* is the clue that the child feels hurt and is trying to "hurt someone else back."

What to do

- Try not to have hurt feelings. If you do, don't show them.
- Don't punish your child for hurting your feelings. Instead, plan ways in which your child can experience some success and have good experiences with other children.
- When you are outside the painful situation, find ways to show that you love your child.
- Spend time together doing something your child enjoys.

Learned helplessness

Clues

The child withdraws, appears to lose interest in most activities, and doesn't try to get your attention.

The very severely discouraged child feels helpless. The child will not try to learn new skills or even actively seek out other kinds of adult attention. Unfortunately, the adults around the child are often themselves discouraged by the lack of effort. A natural reaction would be to say: "He doesn't even try." "What's the use?" *"I give up."*

What to do

- Break activities into small steps in order to provide your child with frequent successes.
- Give lots of verbal and nonverbal encouragement. A smile, a "thumbs up" sign, or just practicing a new skill with your child will help build self-esteem and lead to greater efforts to learn.

If you need more help

Family counselors and other mental health practitioners can provide valuable information and support as you help your child learn new, more constructive behaviors.

Summary

When we understand the goals behind children's problem behaviors, it's easier to change them. Your own reactions to problem behavior will help you identify effective ways of encouraging your child to learn new social skills and to become a more independent learner.

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Stereotypic Behaviors

by Daniel B. Overbeck, Ph.D.

What is a stereotypic behavior?

A stereotypic behavior is one that a child engages in over and over. Stereotypic behaviors seem to happen too often or last too long, and appear to have no functional value.

Boys exhibit *stereotypic patterns* more often than do girls; some children may show more than one behavior. Some stereotypic behaviors are:

- Rocking back and forth or from side to side while sitting
- Flicking a hand rapidly back and forth while looking through the fingers at a ceiling light
- Prancing about on tiptoes, arms flapping like a crowing rooster.

Is it a problem if my child has a stereotypic behavior?

Not necessarily. About 20 percent of normal infants and toddlers show some form of stereotypic behavior. Most outgrow it by about age 4.

At some stages of childhood, a pattern of repeated behavior may actually help in the child's social, emotional, and mental development. Older infants can play peek-a-boo for long periods without becoming tired or bored, and many toddlers rock gently back and forth in bed just before falling asleep.

When does stereotypic behavior become a problem?

Stereotypic behavior may be a problem if your child:

- Prefers the behavior to almost anything—or anyone—else
- Seems to be in some private place that you can't reach
- Engages in the behavior even when interesting toys are handy
- Struggles or protests if you interrupt or try to distract the child into another, more acceptable, behavior
- Keeps up the behavior past the child's fourth birthday.

What should I do then?

Contact your child's doctor. Describe or demonstrate the behavior. The pediatrician may feel that the behaviors are entirely normal and aren't a cause for concern.

But if you or the doctor are concerned about the behavior, get a referral to a child development specialist—usually a psychologist—who is experienced with stereotypic behaviors.

Is there anything I can do at home?

Definitely. Often, a child will experiment with a behavior for a while and then discard it as unnecessary or unhelpful. But family reactions to the behavior may lead the child to keep the behavior.

If your reactions *reinforce* the child's behavior, it becomes more likely that the child will use the behavior again. Unfortunately, some common sense reactions can actually reinforce or strengthen the behavior.

How can I avoid making the stereotypic behavior stronger?

Try to learn your child's reason for the behavior. The strategy to eliminate the behavior must address the purpose of the behavior. Try to follow these basic rules:

Don't let the stereotypic behavior control you. Does your child seem to start a stereotypic behavior while or just after you make a demand or tell the child to do something? By retreating from the demand, you may reinforce your child's use of the behavior to escape or avoid other demands.

Don't reward the behavior. Do you pay more attention to the child or provide an attractive toy when the child does the stereotypic behavior? If you do, your child may learn to relieve boredom or inactivity by using the behavior to ask for your attention or for a toy.

How can I help reduce the behavior?

The child behavior specialist can help you determine if your child's behavior serves a specific purpose. If it does, you and the behavior specialist can decide which responses are likely to reinforce the behavior and which will help reduce or eliminate it.

Some children walk on tiptoe and flap their arms as a way to express their feelings when they are excited. They need help to do two things: eliminate the stereotypic behavior, and develop other, more efficient, ways of self-expression.

There are many reasons why a child rocks back and forth; sometimes it is a way to calm down when the child is upset or apprehensive. If your child has a stereotypic rocking behavior that calms the child, you need to help decrease the rocking and also teach the child other ways to become calm.

The success of whatever strategies you use to manage the stereotypic behaviors will depend heavily on you and your family. Make sure you understand and agree with the approach to be used and which behavior the approach is intended to change.

Self-Injurious Behavior

by Daniel B. Overbeck, Ph.D.

What is self-injurious behavior?

"Self-injurious behavior"—SIB—is any voluntary behavior that causes red skin, bruises, or other damage to body tissue. Children sometimes:

- Bump their heads against mattress, floors, walls, or toys
- Pull on hair until bare patches are visible
- Bite arms, legs, hands, or lips until the skin becomes reddened, callused, or bloody
- Dig or tear at body openings, especially the rectum
- Slap their faces or heads.

SIB is more common among boys than girls. When the child stops the behavior when told or reminded, the behavior is called "mild." The SIB is "severe" if you must physically stop the behavior. But no matter how mild or severe the behavior is, few parents can see their child in pain without hurting, too.

Head-banging is one form of SIB. The child bumps the head—firmly or softly—against other parts of the body, other people, or objects. The child may also hit the head or face with a fist or open hand. Head-banging and some other forms of SIB may appear in any child under 4 years old. The behavior is probably a serious problem only if it persists after the child's fourth birthday.

Why would children try to hurt themselves?

Some children are born with physical disorders that can lead to self-injury. Children with Prader-Willi syndrome often pull out chunks of their own hair or scratch and pick at open sores on their arms and legs. Children with severe Lesch-Nyan syndrome sometimes brutally chew their fingers, lips, and tongues.

Often, the behavior is learned. SIB can be an effective way to influence or control family members and other people.

How can a young child learn such behavior?

There are several ways a child can learn self-injurious behavior.

Early-childhood illness: Children who were often ill as infants—especially those with frequent ear infections—may be much more likely to develop head-banging or other SIB.

Moving the head and neck is one of an infant's first voluntary behaviors. Ear infections are painful, and the child may get some relief by moving the head. When relief comes, the tendency to seek relief by moving the head is made stronger. The next time the infant becomes uncomfortable, the behavior is likely to happen again.

Enforced isolation: SIB can develop when an infant has been confined to a crib or playpen for long periods with little contact with people, toys, or other stimulating things.

Restricted movement: SIB can develop when the infant is not allowed to move for a period of time, such as when immobilized for medical reasons after surgery.

The child's environment plays a big part in determining whether the SIB continues. For the infant or toddler, how the family reacts to the child's experiments with SIB are a critical factor.

What can I do to stop my child's SIB?

Your first job is to stay calm. Take a deep breath and let it out slowly. If the behavior is not severe enough to cause bleeding, just watch your child for a few days. **DO NOT** change how you relate to your child. **DO NOT** rush to stop the behavior except to prevent severe injury. **DO NOT** let your child see how concerned you are.

If the behavior keeps up for several days, schedule a complete physical exam by your child's pediatrician. A physical problem may be causing your child's discomfort.

If no medical basis for the SIB is found, ask for a referral to a child behavior specialist or developmental psychologist who has treated children with self-injurious behavior.

Make an appointment with the specialist as soon as possible. The specialist knows a variety of ways for you to cope with your child's SIB while reducing the risk that you might accidentally make the pattern stronger.

Insist that the specialist keep working with you for as long as it takes to resolve the SIB.

Here are some ways to cope with the SIB:

- If your child is head-banging onto the floor, calmly place a folded washcloth or towel between your child's head and the floor.
- Give your child lots of attention when the SIB is not present.
- Don't rush over and pick up your child while the child is engaging in SIB. Your child may learn to use the behavior as a way to ask for contact or attention.

SOCIAL DEVELOPMENT

1: Normal Development of Social Skills
2: Self-Control in Infants and Young Children
3: Developing Responsibility
4: Teaching Independence: Growing Up and Away
5: Encouraging Cooperation in Young Children
6: Encouragement
7: Natural and Logical Consequences
8: Changing Your Child's Behavior: The Behavioral Approach

Normal Development of Social Skills

by Margaret R. Dunlap, Ph.D.

As with most aspects of a child's development, social skills appear in a predictable pattern and at the child's own rate. Your child learns social skills through contact with other people, but how those skills develop is affected by the child's temperament and stage of development. Here are some stages to look for.

Arm Babies (1-3 months)

Your infant spends most of the time sleeping and eating. But during quiet, alert times, the baby is beginning to learn about the world.

Your baby learns how it feels to be held, cuddled, cared for, and rocked. When you talk to or near your baby, the baby hears the melody of language. The baby begins to make sounds and discovers that people will answer. This is the first lesson in taking turns.

At this age, your infant responds mostly to sensations. Arms and legs wave when you stroke the infant, and a gentle tickle brings a hearty laugh. Faces are fascinating; your baby likes face-to-face contact. By looking away or beginning to fuss, your baby will let you know how much play time is enough.

Lap Babies (3-6 months)

Now your baby is very interested in people and in exploring. The baby relies on your help to move around the room and may fuss after dropping a toy or getting stuck in a tight space. Pick the baby up; the baby will thrive on the attention, and will learn how to communicate with you.

Your baby responds more now, especially to your emotional tones. The baby will look into your eyes and smile when you do and is beginning to laugh, giggle, and cry angrily. Because most learning is through the senses, your baby wants to touch and mouth nearly everything—including you. This helps develop an attachment to you and other familiar people.

Crawlers (7-14 months)

Your crawling baby is more active in seeking you out. The baby is also more aware of differences between familiar people and strangers and may not want to be held by strangers. The baby clearly prefers you and other familiar people but often accepts the stranger quickly.

The crawler is becoming quite affectionate and learns to give kisses and hugs. Feeding the baby is more challenging—or messier—as the baby tries to help you with the spoon. The child can eat finger foods now, and will even help in being dressed.

Water and balls are favorites, partly because they are a chance to play with you or another person. Peek-a-boo, pat-a-cake, and other two-person games are especially fun.

Toddlers (15-23 months)

Your baby is learning to balance dependence and independence. The toddler is more closely connected emotionally to you than ever before but is starting to become a separate person. The baby used to accept anything you did but now begins to be very negative, saying "no" even when that's not what was meant.

The baby is becoming better at getting and keeping your attention and begins asking you to help do jobs that are too difficult. These skills will be crucial when your child starts school.

Don't expect your toddler to share; hoarding toys is more likely. Your child may play in the same area as another but without much contact other than to defend possessions. Boys and girls often play in different ways with the same toys.

This age child begins to share the feelings of others. Instead of crying when another child cries, the toddler will now reach out to touch, rub, or cuddle the injured child.

Two-year-olds

At this age your child needs to feel connected with you and has learned new ways to get your attention. Your child is quite good at imitating and does it regularly. Play with other children often includes copying the others' actions, although the children still don't play together very much.

Often your behavior will be copied, too—especially routines like emptying grocery sacks or the dishwasher, sweeping, or wiping. Encouraging your child's desire to help develops feelings of self-worth and of contributing to others.

Actions interest your child much more than do *results.* Wiping is more important and fun than getting the spilled juice off the floor. Wait until the child is out of sight if you must finish or re-do the job.

The 2-year-old may become quite bossy and possessive—the child is developing a personal identity and a strong sense of "mine and yours."

Three-year-olds

Your child's language sounds a lot like an adult's. The child thinks in words and is much more talkative, using words in place of actions. Experimenting is still the child's best way to learn, so new words may be tried out—including some you don't like. These words will usually drop out if you don't react too much.

Your child's imagination is developing; the child will begin to play imaginary scenes and may even create an imaginary friend. Telling lies is also part of the developing imagination. Lying also shows a growing awareness of "good" and "bad" behaviors—the beginning of a conscience.

Now your child begins to include other children in cooperative games. At first the child will prefer playing with only one other child. The play groups gradually grow larger; sometimes children are excluded. Friendships begin to form.

Your 3-year-old begins to play sit-down games but may change the rules or openly cheat in order to win. The child is becoming good at taking turns in structured games and daily activities. The child likes routine and sameness and may set up rituals that become very important.

The child is more likely now to want to finish projects and loves to have artwork put on display. This is a new way of connecting with and fitting into the adult world.

Sexual differences are more interesting now. Exploring bodies—the child's own and those of friends—is a way to satisfy curiosity. This is a chance for you to teach privacy, self-respect, and respect for others.

From this age on, your child learns social skills by watching and imitating others and by the results of actions. How your child acts in groups outside the home will largely reflect what has been learned in the family. Your child learns from what you *say,* but learns more from what you and peers *do.*

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Self-Control in Infants and Young Children

by Daniel B. Overbeck, Ph.D.

It may be a surprise to some parents, but infants and young children *can* learn to control their own behaviors. Just don't expect a 10-month-old infant to have as much control as a toddler of 26 months.

Is self-control a good thing in an infant or toddler?

Yes—in moderation. A child with too little self-control may tyrannize people with impulsive, demanding behavior. Too much self-control can smother the spontaneity and creativity of early childhood. But self-control that is appropriate for the child's age helps the emotional and social development that comes later.

What does self-control—or the lack of it—look like at different ages?

> Louisa, an 11-month-old, is reaching for an object. She is busy practicing the emerging skill of self-control when she hesitates because a parent says "no" or "don't touch."
>
> Katie, also 11 months old, shows a lack of self-control when she keeps grabbing for an object on the coffee table after a parent told her not to.
>
> Mickey, who is 26 months old, is able to wait with appropriate calmness and patience after his father said "wait." He has acquired the important skill of self-control, at least in that situation.
>
> And when Gerald, also 26 months old, has a tantrum because his mother won't buy him a candy bar, he shows that he can't effectively control his behavior.

Isn't it too much to expect self-control from a little child?

Not really. Don't expect your child to always have self-control in all situations. Do expect your child to grow more able to control impulses and learn to not demand immediate satisfactions.

How can I help my child develop self-control?

There are no recipes that guarantee that your child will develop self-control, but here are some ways you can help.

First: Be consistent.

> Margie's mother consistently enforces the family policy that children are not allowed to grab toys away from other children. Margie learns to expect that grabbing a toy away from her older brother will not work, and that the toy will be returned to her brother.
>
> But Jesse knows that his father might change his mind about a toy Jesse wants. His father has said Jesse can't have the toy, but Jesse has learned that a few yells and protests might get him what he wants.

Second: Have only a few rules. Enforcing a few rules consistently and fairly is better than having many rules but not enforcing them regularly.

> Having a few important rules lets Jose, 30 months old, concentrate on learning the most important rules. His success also means that his parents have more chances to give him praise and hugs for following the rules.
>
> Next door, Jeff—also 30 months old—has had so many rules imposed that he easily forgets many of them. As a result, his parents often feel they must scold him and criticize his behavior. Eventually, Jeff learns that avoiding rules—and failing to live up to them—is easier than following them. He learns that not getting caught is the key to success.

What are internalized controls? Why are they important?

At first, your child will depend on outside reasons—praise or punishment—to control behavior. By being consistent and giving praise when your child follows the rules, you'll help your child learn to rely instead on internal reasons for self control, such as self-satisfaction and a sense of personal strength.

These *internalized* standards help lay the foundation for effective self-control as your child matures.

Mature self-control does not depend on external reward or punishment. Effective self-control as an older child and throughout life means following the accepted or required rules of behavior because the person recognizes the advantages of everyone behaving responsibly.

> Jeremy, a 33-month-old, tries to behave correctly because he wants his parents' approval or fears their disapproval. His behavior is perfect when his parents are around. He's more impulsive and mischievous when he knows his parents aren't around to reward or punish.

How can I help my child want to behave responsibly in the future?

Again, set a few rules and enforce them consistently. If you find yourself scolding or criticizing your toddler too often, maybe you have too many rules. Or maybe the rules call for more self-control than your child has at this point.

Comment in a positive way when your child tries to exercise self-control. Acknowledge your child's efforts even if they are not always successful.

If you *must* criticize, criticize the behavior. Say: "Joey, children are not for hitting," not: "Joey, you're a bad boy for hitting your sister." Or: "Maria, food is for eating, not throwing," not: "Maria, only bad girls waste their food like that."

Developing Responsibility

by Linda M. Levine, M.Ed.

Babies start on the road to adulthood with some basic equipment—inherited traits, their own personalities and reactions to the world, and the good intentions, love, and involvement of their families. They pick up other equipment, including a sense of responsibility, as they grow.

Your job as a parent is not to control your child but to provide the limits and choices that will help your child become a responsible person. You need to help your child understand what the child can and cannot do, how to achieve goals by choosing effective actions, and what the consequences of those and other actions will be.

How early can I start?

You can start right after birth, by always picking up your crying baby. Crying is the only way your baby can send messages about feelings and needs; the baby will soon learn that crying brings help.

When your baby's needs are consistently met, the baby starts to feel good as a person—begins to develop a positive self-concept. The baby feels good about the world, too.

A child's self-concept, whether positive or negative, will affect behavior, motivation, and ability to live up to potential. When children feel good about themselves it's easier for them to learn how to get along with others, and they have the self-confidence to explore, try new things, and attempt to solve everyday problems.

Here are some other ways you can help your child develop these good feelings:

Set a good example. Children are great imitators. Your child will try to do whatever you do. By acting in a responsible way, you set an example for your child to imitate. Show your child gentleness, happiness, curiosity, and satisfaction.

Help your child experience success. Being successful helps your child build feelings of accomplishment. Your child should not fail unnecessarily; when something doesn't go right, help your child cope with the frustration in acceptable ways, such as punching a pillow or pounding on clay.

Match your child's age and responsibilities. Challenge but don't frustrate. A 2-year-old can put blocks back into a box with some help; a 4-year-old can get dressed without much help.

Praise and encourage. Praise reflects *your* opinion of your child's work. Encouragement values the *child's* opinion. Praise is when you say: *"I like your picture."* That's fine, but encouragement is better. To encourage, say: *"You worked hard on that picture."*

Respect your child. You must give respect in order to get it from your child. Don't limit your respect to other adults.

Discipline fairly. Children become discouraged and insecure when they are constantly scolded or punished harshly. Take into account your child's level of development when you consider how to set limits for behavior.

A year-old baby doesn't automatically understand how to pet the cat in a nice way. Don't punish the baby for pulling the cat's tail; instead, show how to touch the cat softly, and watch the baby when the cat is around.

Natural and logical consequences is a method of discipline that can help your child develop responsibility. In this method, you give your child choices, and the child learns from the consequences of the choices. The child—not you—is responsible for the child's behavior. Another parent article deals with this in detail.

The "good" parent and the "responsible" parent

One of the greatest handicaps a child can suffer is being raised by a parent who is "good" instead of responsible. A good parent can become the child's servant, meeting every need and not allowing the child to independently do as much as possible.

When a child has special needs, parents often feel that they must do everything for the child.

Their intentions are good, but they rob the child of self-confidence, independence, and responsibility—especially by doing the things the child can do with just a little help.

Which kind of parent do you want to be?

The good parent:

- Takes on responsibilities for the child
- Overprotects the child
- Gives everything with strings attached
- Overindulges the child
- Gives in to all the child's demands
- Feels guilty without saying so

The responsible parent:

- Permits choices
- Encourages independence
- Gives the child responsibilities
- Refuses to be a doormat
- Knows when to say *no*
- Sets realistic standards.

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Teaching Independence: Growing Up and Away

by Elyda S. Elwinger, Ed.D., O.T.R., CCC-Sp.

Independence begins with the love most toddlers have of exploring unknown territory—as long as it's easy to come back to parents for comfort and security.

Doing something alone helps develop your child's self-image and self-control. With every new success, your child feels more confident, more able, and more willing to tackle new experiences.

What does my child need in order to develop independence?

Independence falls into two major areas: exploring and adapting to the environment, and taking care of personal needs—such as eating and dressing. To grow in these areas, your child needs a secure home foundation.

Your child also needs the emotional security **love** gives. Cuddle and play together, and tell the child: "I love you." Simply talking with your child shows that you value the child.

A secure home life provides physical wellbeing. Your child needs food, a comfortable place to sleep, and contact with people and objects. With basic wants and needs met, your child will be relaxed and eager to learn.

Insecure children don't try new things—there's no safe place to go when things get scary. They cling to familiar objects, people, and places. To feel safe, your child needs **structure**—a regular, predictable schedule. Breakfast follows getting up. Bed comes after supper, in the same place, every night.

Repetition is vital; children learn by doing things over and over. If you read the same bedtime story every night, you know how much your child likes sameness.

Children are great imitators. Copying the behavior of adults and other children is how children learn to get along, socialize, and be accepted. You are your child's first model—your child learns by watching how you care for yourself, try new things, and meet new people. Good models are essential for children with learning problems.

How can I help my child learn to explore?

Make sure your child feels safe and comfortable. If your child is reluctant to explore, introduce new things in a warm, secure setting. Encourage your child to look at, hold, taste, and play with new things. Then slowly withdraw so that your child can explore alone, but stay close enough to give support and comfort. Show that you have confidence in your child's abilities.

Some children—especially those with a delay of some sort—are timid about doing things alone. They've had extra help with feeding and self-care, their physical disabilities may have prevented most exploring, and their attempts at independence have been less successful than those of other children.

Are you afraid to let your disabled child try to do things? Your child is likely to learn your fear and be afraid to try. Don't teach your child to depend on you; dependence, insecurity, and a helpless self-image are disabilities, too.

Your child needs plenty of time and encouragement for each effort. Learn when to help and when to let your child do something alone. The time you spend now to help your child be independent will pay big dividends later.

How can I help with self-care training?

Going beyond the limits of home is part of becoming independent. Another part involves taking care of oneself. You can train your child to take care of self-help activities such as dressing, feeding, and toileting.

Dressing: Start early to encourage dressing skills. At first, have your child help with T-shirts by raising both arms. Later, pull the shirt over the child's head and have the child pull the shirt the rest of the way down. Eventually your child will put the shirt on alone.

Arrange dressing in steps. Lay the T-shirt front-down across the side of the bed. Place shoes in order, ready to step into. To make dressing a little easier for your child, buy clothes a little larger than necessary. Find T-shirts with large head openings. Shoes with hook-and-loop fasteners are easier than shoes with laces. Avoid clothes with difficult snaps and zippers.

Finding time for dressing practice is important when both parents work. You might need to go to bed earlier so there is more time in the morning for dressing.

Make sure your child is ready developmentally and physically before teaching new skills. Most children take several years to learn dressing skills. They start in infancy by helping as they are being dressed; by the end of nursery school or during their early preschool years, they can work buttons and zippers.

Self-feeding is a necessary skill for independence. Look at what your child is trying to do, then adapt the situation so your child can succeed.

If your child is trying to drink, ask yourself: "What can I do to make it easier for the child to hold the glass and drink without my help?" You might try a two-handled cup, a higher tray to support the elbows, or a heavier glass—one with more stability.

Personal hygiene includes bathing, toileting, and brushing teeth. Your child will learn these important skills slowly, by imitating you and by your teaching. Use a daily hygiene routine so that your child learns to do the same thing the same way at the same time every day. Cleanliness is important; it will have a lot to do with your child's social success.

The path to independence

- Encourage your child to *try*. Praise every effort, even those that don't succeed. Show interest in what your child does. Emphasize the positive.
- Break skills into small steps, and guide your child from one step to the next until the child knows the whole skill. Professionals can help with this.
- Leave enough time in your daily schedule to teach self-care skills. Don't rush your child; give lots of practice and repetition before adding new steps. Let the child know what to expect—the child will be more comfortable and won't worry about what will happen next.
- Give your child choices of foods, clothes, toys, and play activities. Making decisions is a big step toward independence.
- Talk and listen to your child. Learn to know when your child feels secure and when the child is anxious or upset. Learn your child's body language. Teach new activities when the child is relaxed and open to learning.
- Love and value your child for who the child *is,* not just for what the child can *do.*

Encouraging Cooperation in Young Children

by Linda M. Levine, M.Ed.

Your baby is unique

Your child's early behaviors are part of the physical and social adjustment to being in a new world. Most babies are "easy;" some are "slow to warm up." A few are "difficult"—they are slow to adapt, can have irregular body functions, and sometimes withdraw when facing new situations.

When babies respond to their parents, parents tend to respond back—they *reinforce* each other. Don't be discouraged if your infant is not very responsive at first. Just make greater efforts to talk to, soothe, hold, and rock the baby.

Building rapport with your baby is the first step in getting the baby to respond. Give lots of attention during daily routines like feeding, diapering, and bathing. The good feelings your baby gets help build love and trust and will encourage your baby to want to please you and do the things you ask.

Toddlers love to explore, hate to cooperate

Your child won't want to please you right away. In fact, some toddlers become less and less cooperative as they start to explore. It becomes a game to touch something forbidden by an adult. Hitting or biting another child is a common way to gain an attractive toy.

How can I help my baby learn to cooperate?

To encourage cooperation, build your child's self-confidence. Let the child make simple choices and do things without your help.

Many toddlers don't understand how to share and cooperate when they play. Provide substitute toys if your child doesn't want to share or wants toys that belong to another child. Physically separate children who are fighting.

Help your baby to solve problems

Self-confidence blossoms when your child solves problems alone.

Suppose your child's favorite toy bunny is hidden under a blanket. It would be easy for you to get the toy, but it is much better if the child makes some discoveries. Uncover the bunny's ears, point to them, and ask your baby to find the bunny. Proudly, the baby creeps over to the ears and uncovers the whole bunny.

Encourage your child to try things independently. Give reassurance that things will turn out well. Self-esteem and confidence come from having successful experiences and receiving lots of encouragement.

How can I encourage cooperation?

Offer choices and explain what the child has chosen. Babies as young as a year old can be offered simple choices every day. Making choices lets the child have more self-control; the child will be more willing to cooperate with you and with other children. And life is a lot easier when you're not in a constant power struggle with your child.

At first, you may have to guess when you hold up two toys and ask your baby to choose, but the baby will soon learn to choose by pointing.

Tell your child that the child has made a choice, even if it's not an intentional one. If your 18-month-old runs off after you say it's time to get into the car, pick the child up and say: "I see you've chosen to be carried."

Choices should be made without disrupting the household routine or interfering with your own better judgement. You can let your toddler decide:

What to wear. Keep a low drawer full of choices *you* select.

What to eat. Offer just two choices: corn flakes *or* puffed wheat; cheese *or* what the family is eating.

If your child is sleepy: The child can nap *or* play quietly.

If your child is warm or cold: Take along a sweater. Let the child decide whether to wear it.

Talk about feelings

Understanding feelings is important for developing good relationships with others and learning how to play cooperatively.

Your child may feel happy, sad, or angry but might not have names for the feelings. Talking about what is going on helps your child become more sensitive to the child's own feelings and those of others:

> "When grandma goes away, I feel so sad."
>
> "Billy gets angry when you grab his toy."
>
> "It hurts Carmen when you hit her."

Point out what is happening

Your toddler can learn ways to cooperate with other children by watching ideas in action. Point these out and comment about the good ideas and the poor ones:

> "Jenny wants the swing, but Gabriel is playing on it. I wonder what Jenny will do? Jenny pushed Gabriel off. Gabriel is crying. He is hurt. His feelings are hurt. Jenny's mother is taking her home. She didn't get to swing because she hurt her friend."

As children get older, they become more able to share and cooperate when they play. Watch carefully and step in when your child needs help. Then back off; your child needs to practice and make discoveries without your help.

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Encouragement

by Sharon Hendrickson-Pfeil, M.S., M.A., CCC

Giving encouragement is a vital part of child rearing. Your encouragement tells your child that you believe the child is a capable person, someone who can learn to make good choices.

Children who feel good about themselves keep working until they master new skills. They enjoy taking on new responsibilities. They expect to succeed.

Children who are discouraged about their own abilities often turn to inappropriate, destructive behaviors. They become "good at being bad" to get attention by misbehaving. Or they just give up.

How are encouragement and praise different?

Real encouragement helps your child become self-sufficient, while praise can backfire and actually be discouraging. Praise evaluates the child or the child's work as "good" or "bad." Encouragement separates the deed from the doer.

Most of us use both, especially with very young children. But the more real encouragement you give, the stronger your child will be as an independent learner.

Some examples:

Encouragement

- You're learning!
- That looks like fun!
- You got it!
- Now you know how!
- You can do it!
- Thank you!
- You kept on trying and you learned how!
- You worked hard!
- You really thought about it that time!
- You're really paying attention!
- You're learning!
- You're really listening!
- You're really sharing!
- You're really taking your time!

Praise

- Good boy!
- Good girl! (Child may wonder: If I mess up, am I still OK?)
- I'm proud of you. (Child may wonder: What if I can't do it right or I forget next time?)

How do we discourage children?

Avoid outright discouragement at all costs. This teaches the child that it's useless to learn or to try to take on new responsibilities. It also destroys trust in adults.

But we often discourage children without realizing that we are doing so. Here are some examples:

- No—not like that!
- Didn't you listen?
- You NEVER pay attention!
- You never take your time!
- You never listen!
- Your brother never behaves like this!
- Your sister already knows how.
- Why can't you be like . . . ?

How can I teach my child to correct mistakes?

The aim of *correction* is to change behaviors in an encouraging, constructive way. Start by assuming that your child's mistake was not deliberate. By taking a positive approach, you help your child learn new behaviors.

Some words that help with correction are:

- Oh-oh!
- Take your time. You'll get it.
- Let's try it again.
- Let's try *this.*
- Let's try another way.

- Let's try a new way.
- Let's practice remembering that.
- Watch me again.

What are some other ways to encourage my child?

- Help your child feel worthwhile by spending quality time together.
- Look at drawings, block creations, and schoolwork together.
- Don't judge—just *share.*
- Buy or make educational toys. If your budget is tight, explore resale shops—they often have a good selection of children's toys. Ask your child's therapist or teacher for ideas about appropriate items for your child. Give a few toys at a time—most children, especially those with disabilities, are overwhelmed by too many items at one time.
- If your child is in school, set a regular time for homework. Provide a quiet, well-lit area and perhaps a snack.
- Really *listen* to your child. Give your full attention when your child shares experiences. Make sure to show your appreciation.
- Celebrate successes, but don't judge failures.
- Let your child see how *you* learn.

Summary

Encouragement means being there for your child and recognizing the child as an independent human being who will learn if given the chance. If your child is sure of your caring, confidence, and respect, the child will develop self-esteem and will be stronger in all areas of learning.

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Natural and Logical Consequences

by Sharon Hendrickson-Pfeil, M.S., M.A., CCC

Every decision has a consequence. You can use consequences to help your child learn to make responsible choices and to develop mature behavior.

Consequences can be *natural*—arising from behavior without your intervention—or *logical*—planned and applied by you.

A child who loses popcorn money for school will miss the treat. This is a natural consequence; you've done nothing to bring it about. Logical consequences also directly relate to the child's behavior. But they are planned, to help children reduce specific misbehaviors.

In working on a problem behavior, you may choose to stand back and let your child face the natural consequences of the behavior. Or you may explain some logical consequences to your child, then let the child select one and experience it.

Are logical consequences different from punishment?

Natural and logical consequences both teach that the child has the power to solve problems. This sense of personal capability helps develop a sense of responsibility. Providing natural and logical consequences show that you trust your child to work out solutions.

Punishment teaches that only adults have power, so only adults are truly responsible. It usually does not teach why responsible behavior is important because the punishment is often not related to the behavior.

Logical consequences, if well planned and presented, encourage and strengthen the child. Punishment only damages the child's self-esteem.

Here are some of the important differences between punishment and logical consequences.

***Punishment*:**

- Makes the child the object of your anger, which may be expressed directly or indirectly
- Focuses on guilt
- Is not necessarily related to the misbehavior.

Logical Consequences:

- Avoid anger and power struggles. The child is not judged or scolded.
- Focuses on problem-solving
- Always relate directly to the misbehavior.

How do I select the right logical consequence?

Logical consequences should be as close to natural ones as possible. Here are some examples of appropriate logical consequences.

Behavior: Child throws food on the floor.

State logical consequence: "If you throw your food, it will be all gone. Then there won't be any more until lunchtime."

Action: If child continues throwing food, let child experience the natural consequence of an empty plate. Assure child that you will fix a good lunch later.

Behavior: Child, age 1½ years, is fascinated by electric outlets. Child repeatedly tries to poke finger into one.

Demonstrate logical consequence: Give warning ("That's a no-no") then set child in playpen.

Action: Each time child approaches the outlet, leave child in playpen a little longer. Child soon learns that approaching the electric outlet is choosing to be taken to playpen.

Behavior: Child plays roughly and noisily in front of the TV while you are watching a program.

State logical consequence: "We're watching the TV. You can play quietly with a book or your doll or you can play in the other room. You decide."

Action: If child doesn't settle down, say: "I see you'd rather play in the other room. Come back and sit down with us when you're ready." Then follow through; guide child into the other room if necessary.

If child continues to test you, simply say: "I see you're still not ready to play quietly. You've decided to stay in the other room. You can decide where you want to play again tomorrow night." Don't scold or explain further. Gently but firmly show that no more play in the living room will be permitted tonight.

Behavior: Child has difficulty playing with other preschoolers and frequently hits them and grabs their toys.

State logical consequence: In a firm, friendly voice, give child a choice. Child can play nicely, or sit alone for some "time out," until ready to play without hitting or grabbing.

Action: Assure child that there will be another chance soon, then put child in time-out area. Don't scold, apologize, or explain—this avoids conflict, and you may not become the target of pleading or tears. If child leaves the time-out area to test the consequence, return child gently but firmly. Don't repeat explanations or make eye contact, which the child may find rewarding.

Some problem behaviors may be approached in one of several ways:

Behavior: Your 3-year-old does not like to ride in a car-seat. Child whines, wriggles, and protests during entire trip.

State logical consequence: "When you make noise, I can't drive. Then we have to wait until it's quiet before we go."

Action: Each time child begins to whine or protest, pull the car to the side of the road. Allow extra time when traveling together, and introduce this on a weekend or over a few days when you're not feeling hurried.

Alternative:

State logical consequence: "If we get home on time, there'll be time for you to play outside. If you fuss and cry so we can't, there won't be time later on to do something fun."

Action: If child fusses in the car, don't scold. When you get home, say: "Uh-oh, you fussed in the car. Now there's no time for playing. You can decide again next time."

How do I explain and carry out logical consequences?

Always tell your child about the logical consequences of choices *before* the child misbehaves. The child must know that there is a real decision to be made.

Don't carry out unpleasant consequences when you're angry. Your tone of voice will make this seem more like punishment than a learning experience. And it won't work.

Be friendly and matter-of-fact when you explain choices and when you follow through. Don't scold or nag.

Be encouraging. If your child has lost a privilege as a logical consequence, make sure the child knows that soon there will be another chance to decide.

Natural consequences speak for themselves. If the child complains about these consequences, express your confidence that the child can solve the problem.

My child has a disability. Will natural and logical consequences work?

Yes! Keep your child's limitations in mind when you plan, explain, and carry out consequences. If your child has limited language comprehension, give simple explanations and consequences.

Include older children in a family council when you plan house rules and logical consequences.

Where can I find help in planning natural and logical consequences?

Some school districts and community agencies offer workshops and materials for the Systematic Training for Effective Parenting (STEP) program. The STEP program teaches specific techniques for using natural and logical consequences and lets parents share their experiences.

A family counselor or psychologist can help you tailor logical consequences to your child's needs. Help may also be available through your child's school—ask the school counselor.

For more information

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Changing Your Child's Behavior: The Behavioral Approach

by Robert J. Bennetti, M.Ed.

What is the behavioral approach?

The behavioral approach is a way to change your child's behavior by using basic principles of learning. It is concerned with what your child does—how the child responds to the environment.

The behavioral approach translates inner events—such as emotions—into things that can be observed and measured. To measure "laziness," you can see how long your child takes to finish a job. You can measure "angry" by how often your child fights. To measure "fussy," you can find out how often your child cries. This approach lets you work to change specific behaviors and determine whether the change happened.

How does this approach differ from other approaches?

The major difference is the emphasis on behavior. Emotions, thoughts, and feelings are important, but they are hard to observe and difficult to predict, control, or change.

Some other approaches try to change how a child feels or what the child thinks about parents and playmates in the hope that the child's behavior will change. The behavioral approach is more concerned with the child's behavior—the idea is that *a change in behavior will change the way the child thinks or feels.*

Another important difference is the belief that a child *learns* how to behave—that behavior is not caused by underlying drives or characteristics that the child is born with.

What are some of the principles of the behavioral approach?

The most important behavioral principle is that **no behavior occurs in isolation.** Behavior doesn't just happen—something else always happens first and sometimes causes the behavior. And there is always a consequence that follows the behavior.

There can be any of three major consequences: The behavior can be rewarded, punished, or ignored. When you reward a behavior it is more likely to occur again. When you punish or ignore a behavior it is less likely to occur again.

Behavior change—learning—occurs when you let your child experience the consequences of behavior. Your child is responsible for behavior *and* for the consequences that follow.

Of course, parents have been using rewards and punishments for years. The key is in *how* they are used. To begin with, you must set up rules or expectations for behavior in advance. With your child, review the behavior you expect. Be specific. Then go over the consequences, both negative and positive. The child must clearly understand the consequences of behavior.

By knowing the consequences ahead of time, your child can choose how to behave and must accept the consequences for that behavior. Your child's misbehavior is now the child's problem—not yours. And the reward for the behavior you desire will be the child's to enjoy. This eliminates the need for nagging, scolding, lecturing, and threatening.

The second principle is **consistency.** There is no single parenting skill more important than consistency.

You'll be much more effective in managing misbehavior and teaching your child more acceptable forms of behavior when you respond in a consistent manner. Inconsistency leaves children confused, mistrustful, and more likely to manipulate their parents. Inconsistency also teaches children that one way to get attention—a reward—is through misbehavior.

Consistency means agreeing on what is expected of the child as well as what the consequences are for both misbehavior and good behavior. It also means that both parents work together as a team.

The final principle is to **pay more attention to your child's good behavior and accomplishments** and less attention to the misbehavior and failures.

It's easy to ignore your child's good behavior and devote your time and attention to the misbehavior. You can more effectively manage behavior by using the opposite approach. Praise your child as a reward for being cooperative, helpful, or well behaved. Rather than scolding or lecturing, try ignoring your child when the child is disruptive or misbehaving. Ignoring undesirable behavior can be a very powerful way of disciplining your child.

My child has a disability. Will the behavioral approach work?

It should—the behavioral approach provides some of the most effective techniques to manage behavior. It's easy to learn, easy to teach, and easy to use. And it doesn't rely heavily on the child's verbal ability, so it works with children with even the most severe speech delays or intellectual or sensory impairments.

And, since the approach is concerned with how your child *acts,* you'll be the first to know if it works.

For more information

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FAMILY SUPPORT

1: Families with Children with Disabilities
2: Having Another Child
3: Grandparents
4: Brothers and Sisters
5: Good Grieving
6: De-stress Your Life
7: Giving and Getting Support
8: Taking Care of Yourself
9: Humor for the Health of It
10: Going Out!
11: Dealing with Your Child's Difference
12: Being Partners with Your Child's Service Providers
13: Parents as Advocates for Children
14: Organizing Your Child's Care
15: Planning Transitions for Your Child
16: Understanding the IFSP

Families with Children with Disabilities

by Kathryn Norgard, Ph.D.

One Family

One day I walked into my waiting room to meet some new clients. Waiting there was a family—a husband, a wife, and their two-year-old daughter. The family looked like many others I've met in the waiting room, but the child had a glow that I noticed almost immediately.

Molly, the daughter, had a developmental delay. Her brain did not function as it should, and she couldn't do many of the things expected of a two-year-old. As we sat in my counseling office, Jeff and Alice took turns describing Molly's medical and social history. I realized how sad and angry they were about their daughter's situation.

Jeff bellowed and sputtered about this doctor or that medical facility. He generally sprayed his anger. Alice sat teary-eyed and seemed to shrink away as her husband spoke. All the while, Molly, who was blind, happily explored a new portion of the world with her hands.

I had no medical magic to offer. Instead, I focused on what I do have—the ability to help people examine and make changes in their relationship patterns. These parents were having difficulty reaching out to one another in a loving, meaningful way. Jeff was totally involved in anger; Alice seemed immobilized by sadness and fear.

Jeff was irritated by my gentle questions about their marriage. He responded grudgingly. I sensed that he would not have been in my office had his employer not insisted that he seek counseling for his angry outbursts at work.

Jeff said he had expected a normal, healthy baby—one who would require only minor changes in the life he shared with Alice. He said he loved Molly and was torn to emotional shreds every time he thought about her limited future and short life expectancy.

Alice expressed her disappointment through tears and sadness. Since Molly's birth, Alice just didn't have much energy for doing what had always been normal, everyday tasks. Even after two years, Alice still cried a great deal. She managed to maintain her part-time job outside the house but found it more and more difficult to confide in Jeff because of his angry responses.

One result of Molly's birth was that Jeff and Alice had lost one another. They had spent the first two years of their marriage traveling together, having long talks, eating at restaurants, and participating in and attending athletic events. Now, they traveled to distant medical clinics and to appointments with doctors and physical and occupational therapists. Meals outside the home were caught on the run as they tried to balance Molly's needs and their own lives. They now participated in athletics separately since Alice felt that one of them should be with Molly rather than trying to get a baby-sitter. At the end of the day they talked only about Molly and her needs and what was going to happen next with the specialists.

As I listened to Alice and Jeff, Molly continued to radiate the joy I had seen first in the waiting room. The course of this couple's counseling centered on helping them enjoy Molly's special gifts and on rekindling their own neglected relationship. They needed to take charge of their own family mobile.

The Family As a Mobile

A mobile is a collection of objects that are in constant motion within a framework. A family is the most versatile, ever-changing mobile that ever existed—a living mobile, made of human personalities. The family framework starts with a man and a woman, then a mother and a father. Family members affect each other intellectually, emotionally, spiritually, physically, and psychologically. A family is an art form, a mobile. As with any art form, creating a family mobile takes work.

Jeff and Alice were no longer meeting one another's emotional and physical needs. They had strayed from one another. They had lost the ability to be creative with their own family mobile.

Parents As Architects of the Family Mobile

Every person is born into a family and the lessons learned in that family last a lifetime. Partners in marriage have the special job of "architecting" the family mobile. They have a special responsibility to each other: They must take good care of the relationship so that the love that brought them together changes and grows through the years. The bond between the two architects needs constant nourishment.

Children bring new challenges and new stresses to the family mobile. A child is a big addition to the family structure and makes it necessary to rebalance the mobile. The architects must discover how the child will fit into the mobile. The ever-changing mobile can help the parents develop patience, creativity, hope, and commitment. Crafting the family mobile is one of the most demanding and rewarding careers there is.

Molly was a very special addition to Jeff and Alice's family mobile. They needed to learn to appreciate and support each other and the love between them so that together they could carry the joys and sadness Molly brought to the family mobile. They needed to find time to spend together. They needed to talk about things that gave them pleasure, without Molly at the center.

The Family As a Center for Human Relationships

Human relationships happen whether or not anyone labels them. Learning to deal with and live with other people takes a lifetime. Time can never be brought back, and like money, it is spent one way or another. Once spent, it is gone, except for the memory.

Jeff and Alice were spending their time and creating their scrapbook of memories. When they examined the memories they were creating, they were able to creatively take charge of their family. Jeff decided to find ways to discharge his angry and hurt feelings other than spewing them around in the family. Alice sought avenues outside the family to deal with her chronic grief and sadness. They found ways to build a bridge between themselves so they could help one another with their intense emotions. They found ways to create other emotions within the relationship, adding balance to their lives.

Alice and Jeff each learned that they could not perfectly care for one another's needs any more than they could perfectly care for Molly's special needs. They learned to do the best they could. They learned to talk to one another and to accept their limitations just as they had to accept Molly's.

Special Children Need Special Families

Few parents are able to fully anticipate the changes they must make in their family mobile when a child is born. The family structure must be rebalanced whenever a child—especially a child with disabilities—is added. Special children need special families. Children with special needs can bring about the creation of that special family.

When a child is born with disabilities, the parents immediately face the need to adapt to that child. When a child's needs change later—through an accident, development of a physical disability, or the discovery of a developmental delay—the parents must learn new ways of caring for that child. Each situation is a loss, and parents need the chance to grieve that loss. They also need to learn how to support one another during the grief and loss.

It is important to examine how your family is special and how your family can create a balance that meets the needs of *all* family members—adults and other children in the family, as well as the child with special needs. Every person in the family has needs, and the family architects must make sure that those needs are met.

For more information

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Having Another Child

by Kathleen Walden DeVerna

The decision to have a child is a very private one, but for many families with a disabled child, it seems more complicated—and more public. Other people may wonder if you are making a wise decision. You may be wondering the same thing.

You may be wondering:

- What if this child has problems, too?
- Will there be enough time, money, and energy for everyone in the family?
- Is this the right decision for us?

There are no easy answers, but no matter how it seems, it's a decision that only *you* can make for *your* family.

You may have many questions and concerns—and stress—deciding if you want to have another child. Disabilities happen. They can happen in any family and under any circumstances. Being informed of all the known risks may help reduce some of the stress.

When do disabilities occur?

Many disabilities happen before, during, or after birth. They can be inherited, just as hair or eye color is inherited. Or they may be caused by something in the environment. Some of the risks can be measured and some cannot.

In some situations, the chances that inherited disabilities will affect other babies can be reliably estimated. In many cases, tests will tell if a baby is actually going to have problems. A doctor who specializes in this area can give you lots of information and support to help you decide whether to pursue this type of testing.

Other disabilities that occur during pregnancy are caused by rubella (German measles) and some other illnesses. Medications and even routine household chemicals may cause stress to an unborn child. A *genetic counselor*—a specialist who can interpret information on birth defects for people who are interested in how their family may be affected—can help you understand the environmental and hereditary possibilities. This information may help you feel more confident about your decision.

There are many ways things can be worked out. Some—but not all—parents decide to have another child. Others adopt or become foster parents. The decisions may be difficult, but each family must decide what is best.

What can parents do?

As a mother, taking good care of yourself before and during pregnancy is one of the best things you can do for your baby. Here are some things your doctor may advise:

- Get medical care early and throughout pregnancy
- Get plenty of rest
- Eat a balanced diet
- Exercise regularly and moderately.

These recommendations are not new, but they are still very important to mother and baby.

The baby shares almost everything the mother takes into her body. Smoking and using alcohol and other drugs may cause some preventable problems. Special precautions are necessary if an x-ray is needed. Being cautious during pregnancy can give this baby the best start possible.

We're worried. What can we do?

This can be a difficult time emotionally—even with good genetic counseling and medical care before, during, and after the birth. Most parents worry about the health and well-being of their unborn child. The worries may be much more intense when there is already a child with delays. Talking openly about hopes and fears can reduce some of this stress—keeping it bottled up inside will only add to it.

What about our other children?

No two siblings are the same—even identical twins are very different. Try not to compare children; each child has personal strengths and needs. One may not learn as quickly as the other, but they are both equally important.

Parents often comment on how easily nondisabled children learn skills which are so hard for the child with delays. Try to appreciate each child's special skills. The child who has to work hard is learning one thing and the child who learns more easily is learning different things. Look at and appreciate each child's own personality and abilities.

Try to set aside a special time every day for each of your children. Brothers and sisters have always had to compete for their parents' time and attention. It's no different when one child is delayed. Knowing a bit of special time is coming can take some of the pressure off.

To get the attention they need, some siblings of children with disabilities develop special needs of their own. Make sure you give attention *before* the nondisabled child develops problems with behavior or learning.

A child with delays may feel pressure to keep up with brothers or sisters. The best any child can do is try to reach his or her own full potential. Your encouragement can help tremendously.

Respecting children for who they are teaches them to respect themselves. Expecting them to be the best they can be challenges them. With this type of attitude a child can learn a great deal from a brother or sister, no matter how capable the sibling is. *Every* family member has a lot to contribute to the process of growing, learning, and being together.

Grandparents

by Judith C. Vestal, M.A., O.T.R.

Sometimes telling the grandparents can be the hardest part of having a child with disabilities. You and the grandparents have hopes for the new baby. When the hopes are not met, it can be as if a child has died.

How will the grandparents react?

Parents and grandparents expect their relationships with each other to change when a grandchild is born. Grandparents expect their children to appreciate how difficult parenthood can be, and to better understand the parent's role. Parents expect to be seen as equals since they now have something in common with their own parents. The birth of a child with disabilities can alter this relationship.

Accepting that a problem exists may be difficult. Sometimes the grandparent sees a problem first and may urge the parents to seek more information or medical guidance. Some parents may feel the grandparents are negative and noncaring ("They just *want* something to be wrong").

Other grandparents deny there is a problem. They might say, "There's nothing wrong, so don't worry about it." This closes the door to direct communication about the child, and you may feel you don't have the grandparents' support. It's best for everyone to discuss these issues openly and honestly.

What else should we discuss?

It may be hard to lay the ground rules for your new relationship with the grandparents. To prevent misunderstandings, talk about situations as they occur.

It's hard for grandparents to stop feeling responsible for their children. If you feel the grandparents are interfering, talk it over with them. Explain that you need your parents' love and support, but the baby is *yours* and you will decide about the baby's needs.

Some grandparents may be so careful about not interfering that they are not involved *enough*. Talk about this, too. They may not realize how much they're needed.

Helping grandparents relate to a child with disabilities

Often grandparents need to be taught how to relate to a child who doesn't make eye contact, babble, or cuddle.

Your child may use many other clues to show the need or desire for contact. The child may make subtle changes in movement or use a more relaxed posture. Sometimes a particular sound or touch will quiet the child—this may be the child's way of saying, "I like that." Maybe your child's head turns when the cheeks are stroked.

Help the grandparents learn to spot the clues; being sensitive to how babies respond is an important part of communicating with them.

How can grandparents help?

Grandparents can be wonderful sources of help. They can:

- Baby-sit. If they prefer not to baby-sit, they might offer to pay for a sitter once in a while.
- Take the child to clinic appointments or therapy visits
- Provide emotional and maybe even financial support
- Spend time with other children in the family. Often parents must spend so much time and energy with the disabled child, little remains for the other children.
- Provide information. They've raised children of their own and may have just the right answer in difficult situations.
- Make teaching or therapy equipment, such as an alphabet book or a book of magazine pictures. A grandparent with woodworking skills might design and build a particular piece of equipment.
- Save items your child can use (such as cereal boxes for stacking and building).

Some grandparents may be uncomfortable caring for the baby because they think the baby is fragile. Helping with daily tasks such as feeding and dressing will build confidence.

What are some of the "rules" for being a good grandparent?

Be open. Grandparents may be frustrated because they want more information but don't want to ask too many questions. By being open, grandparents let you know they care and are concerned. They can invite you to share only as much as you are comfortable sharing.

Respect your rules. Grandparents should enforce your rules for behavior as if the rules are their own. If you don't allow TV after 8 p.m., they shouldn't, either. Your child has special needs, not special privileges.

Accept facts. It's natural for grandparents to want to make everything okay. But telling you that your child will outgrow a disability makes it difficult to deal with the reality.

Don't criticize. No matter how right grandparents are, criticizing is not going to change anything. Understanding and gentle guidance might.

Summary

Most grandparents are very supportive of families with children with disabilities. Parents of children with disabilities tend to have fewer friends and rely on grandparents more than other parents do. By sharing time and understanding, grandparents can be a valuable part of your family's support network.

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Brothers and Sisters

by Judith C. Vestal, M.A., O.T.R.

Many things go into how a child feels about a sibling's disability, including the age and sex of the disabled child, the nature of the disability, and the age of the nondisabled child.

Children have many of the same feelings as do their parents. They feel grief at losing the brother or sister they had hoped for. They may be frustrated because the disabled child can't play with them or seems to get more attention. They may be confused about the disability itself or their own role in the family. Understanding how siblings feel can help you deal with them more effectively.

How is your family different?

Several things may be different in families with a child with a disability. Here are some things which may affect how nondisabled children relate to the child with a disability:

- Family routines are altered. Activities such as going to the park or on vacations may be more difficult. It may seem that everything has changed because of the disability.
- You may spend more time and energy on caring for the child with a disability. Little time, energy, and attention remain for the other children. Plus, caring for the child with disabilities can be expensive, leaving less money to spend on the other children.
- The other children may not understand the disability. They may worry that it is contagious, or that they are responsible in some way. Older children may worry that their own children may be affected by similar disabilities.
- Older children are often asked to care for the disabled child. The added responsibility might mean sacrificing their own social lives. They may wonder if they must continue to be responsible as adults.
- Brothers and sisters may feel they must somehow "make up for" the disabled child. You may not intend it, but the other children often feel indirect pressure.
- Siblings may be confused by how you react to the disability. Your reactions may vary according to how much stress is in the family at the moment. Children become confused when parents react one way one minute and another way the next.

What affects the way siblings relate to each other?

How much responsibility the children have for the child with a disability plays a big part in how the children relate to each other. Children who have too much responsibility feel overburdened—older girls often are given more responsibility than boys. Make sure your nondisabled children have time for their own social and academic interests.

The age and birth order of the other children also makes a difference. Nondisabled younger children may not get as much attention as they would if the older child did not require so much of your time. Younger boys seem to have the most adjustment problems, while firstborn children seem to be less affected by a younger sibling's disability.

Another very important factor is the way *you* adjust to the disability. Children take on their parents' attitudes and reactions. When you are open and willing to talk about the disability, it's easier for the nondisabled children to ask questions. Your open attitude tells the child that it is okay to talk about the disability, what is happening, and how it affects the family.

What do nondisabled children need from the family?

They need information. They need to talk about the disability—why and how it happened. Refusing to talk about it can cause confusion and misunderstanding. Give information openly and honestly.

Siblings are often very concerned about what is expected from them as they get older. They wonder what will happen to their brother or sister when you're no longer able to care for the child. Do you automatically assume the adult siblings will be responsible? The whole family should make long-term plans, long before they are needed.

They need time to be with their own friends. They need to feel that they have lives of their own.

Summary

Brothers and sisters of a child with disabilities face issues that other children don't face. Be sensitive to their needs and be ready to deal with them by providing information and support when they need it.

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Good Grieving

by Linda H. Sampliner, Ed.D.

What is grief?

Grief is a normal process of adjustment to a significant loss. It feels like intense sadness or sorrow.

The different kinds of grief

The most common grief is a reaction to an expected or unexpected death. When we know someone we love is going to die, we feel *preparatory* grief. The person is still alive, but we begin to miss the person and get emotionally ready for being without the person.

When the death is unexpected, we feel *reactive* grief. We tend not to believe the death really happened. We feel out of control, frightened, and disoriented.

Another kind of grief occurs after losses which do not involve death, such as when a child is born with severe abnormalities. The family members need to grieve for the perfect child they hoped for before beginning to bond with the child they do have. Letting go of the dream and making new plans become important.

We can also feel grief when:

- We move to a new location.
- We change jobs.
- We get divorced.
- Grown children leave home.

How can I help myself and my spouse to grieve?

Let yourself feel your feelings. Don't pretend that it doesn't hurt. Let words, tears, and touching express the pain. Here are some other ways to express your feelings:

- Write a letter to the one who is the source of your grief. Tell the person how you feel.
- Say good-bye with love.
- Record your message on an audio or video tape.
- Put items used by or gathered for the loved one in a remembrance box. You might include clothing, toys, photos, or handmade items. Let the family help decorate the box.

How can I help my surviving children grieve?

Siblings may be confused and frightened by your sadness over the loss. Children often feel guilty when they are unable to comfort their parents or make their grief go away.

Be honest. Talk openly about what is happening to the family and why it is occurring. Talking includes the children and lets them express their feelings. You can also:

- Tell them and show them that it is okay to cry and to feel sad.
- Let them grieve in their own way. Not everyone screams and cries—some of us become quiet and thoughtful.
- Encourage them to talk about their brother or sister.

There are many ways for children to share their thoughts and feeling about a lost loved one:

- Talk about the most special time you shared with this person.
- Describe the person's favorite place.
- Read the person's favorite story.
- Play the person's favorite game.
- Cry together—crying is a natural expression of sadness, not a sign of weakness.
- Keep a journal of your thoughts and feelings. This can help you identify what you are feeling, so you can work it out. A journal can also show the progress you are making in recovering from your grief.

What is "magical thinking"?

Children around the world believe that they are the center of the universe. Here's a little talk you might have with your child:

> "When a brother or sister like yours (dies/is born with health problems), some kids I know worry that they might have done something to cause it, even if they don't talk about it. Does that make sense?"

The child might say:

"No!"

"Yes, but not me."

"Yes, and I'm glad you said it."

What is the *worst* thing I can do when a child dies?

The very worst thing is to pretend the child never existed. Not talking about the child merely denies the feelings. Discussion does not make the loss worse.

People sometimes feel that mentioning the child who has died will remind the parents of the loss and cause bad feelings. Parents whose child has died think about that child constantly! Talking about the child helps them get out the thoughts and feelings that already consume them.

How can I recognize recovery from grief?

Families are recovering from grief when they:

- Cry less frequently.
- Can remember the loved one with less pain and more joy.
- Feel normal or more like they used to for many days.
- Return to work.
- Are able to put their lives back together.
- Get on with the business of living.

It is normal to have some pain forever, and it is normal to always remember. Some points to keep in mind are:

- Hurt lessens with time.
- Grief is different for everyone.
- Having down days is okay—feel the feelings, don't run away from them.

Summary

Grief happens to people when they experience a significant loss. It takes many forms and has many causes.

For children, talking is more important than answers. Share the mourning and respond to fears by being available and talking together.

You can help yourself, your spouse, and your surviving children cope more effectively with grief by sharing your feelings with each other. Shared tears can connect the living.

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De-stress Your Life

by Karla Garis, B.S.

What is stress?

Stress is outside pressure that results in internal tension. Stress is a part of daily life, and certain kinds of stress are actually helpful. But too much stress on your mind and body can make you miserable. It can also make you sick and sometimes even shorten your life. In the United States, 80 percent of illness is stress related.

What are the main causes of stress?

One of the main causes of stress is change—especially change that is sudden or disagreeable. Too many changes or change that is too drastic often results in harmful tension. If your home life is a constant hassle, try to figure out why.

Here are some common changes that may cause stress:

- A new baby
- A major illness or accidental injury
- The death of a loved one
- The loss of friends due to moving
- A marital separation or divorce
- Children's growing pains
- Trouble with in-laws
- Money problems
- The retirement of a family member
- Physical changes.

As the parent of a child with a disability, you face additional stress. Here are some extra "traps" you can fall into:

- The inability to say "no" to requests from others
- Living in the past
- Worrying about the future
- Seeing all things as major issues or problems
- Feeling guilty because you can't do enough for your child
- Interference from grandparents
- Comparing yourself and your child to others
- Trying to save enough money to care for your child after your death.

What are the symptoms of harmful stress?

Stress from excess tension can lead to anxiety and depression. Here are some warning signs:

- Nervousness
- Dizziness
- Inability to slow down or relax
- High blood pressure
- Abnormal eating habits
- Ulcers
- Fatigue
- Sleeplessness
- Inability to concentrate
- Boredom
- Lack of interest in life
- Feelings of worthlessness and hopelessness.

What can I do to help my family cope?

A lot can be done to keep tensions within reasonable limits and reduce stress at home:

- Clear the air—talk over family problems. Schedule a family meeting and keep the atmosphere relaxed and cheerful.
- Respect the privacy and individuality of family members.
- Set realistic goals for yourself and other family members.
- Establish a sensible daily routine that allows time for everyone to relax and get adequate exercise.
- Try to plan to avoid making too many big changes at the same time.

What can I do to control my own stress?

- Exercise regularly. Pick an activity you like and stick with it. You'll look and feel better.
- Take care of yourself—eat right and get enough sleep.
- Don't procrastinate. Decide what you need to do and do it. The immediate feeling of accomplishment you'll feel will make everything else seem easier.
- Pace yourself. Don't try to do everything all at once. Take time out from a heavy workload to regain your energy.
- Take time to look at yourself. Assess the amount of stress you're feeling and take steps to reduce it.
- Share your feelings. Talk out your problems with someone who knows you and will listen. Just talking about your troubles can help you solve them.
- Schedule leisure time—do things you enjoy, and take regular vacations.
- Take the time to find out what is and what's not important in your life.

Your attitude can make a big difference in your life!

If you think something good will happen, chances are that it will. Positive thoughts are more likely to bring positive results. Try some of these:

- Don't take yourself too seriously.
- Be kind to yourself.
- Associate with positive people—it's contagious!
- Keep a journal of your experiences. Focus on the good points of each day.
- Make a "worry jar." Write your concerns on paper and put them in the jar. Take them out and worry about them for 30 minutes, once a week. That way you won't waste your time and spoil your entire week by doing something as unproductive as worrying.
- Give someone a hug, a smile, or a friendly word.

Take charge of your thoughts!

What you say to yourself—out loud or in your head—can make a difference. Your conscious thoughts direct your actions, and after awhile you will start to believe what you tell yourself.

Try this approach to taking charge of your "self-talk":

Start by listening to yourself. What kinds of things do you say? Are your words negative? ("That was stupid." "I can't do that; there's no point in trying." "I'll never be able to do that.") Or are your words positive? ("I'm proud of my work." "I did fine." "I can handle that situation.")

Replace your negative words with more positive words. As Henry Ford once said, "Whether you think you can or you think you can't, you're right." People like to be right—why not be right about all your positive thoughts and possibilities?

Believe in your abilities. When you believe in something, your mind collects reasons to support the belief. If you doubt your own abilities, you'll find all sorts of reasons why you really aren't very capable. But if you believe you *can* do something, your positive attitude will generate the power, skill, and energy you need to reach your goal.

Be your own best cheerleader.

What you say to yourself affects how you see yourself and the world around you. Give yourself the encouragement and applause you deserve.

Paint a pretty picture! Visualize your good points. Picture yourself doing well in difficult situations. Golfers' techniques improve when they visualize or picture a perfect swing.

Take a bow. Don't brush off compliments—take credit for a job well done. When someone gives you a compliment, simply smile and say, "thank you."

Can you de-stress your life? Accept the challenge—say: "Yes, I can!"

For more information

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Giving and Getting Support

by Kathryn Norgard, Ph.D.

What is support?

Support is a type of communication. It has many forms—it can be physical, spiritual, intellectual, or emotional. Everybody needs support, and the kind we need changes often.

Sometimes we need someone to "be there" or to hold us. Or we might need someone to just listen. Maybe we need help in getting an overwhelming job done. Sometimes we need someone to "go to bat" for us, to fight for our cause.

Support also comes from inside. Sometimes, we need to stop and reflect to find the strength to meet the next challenge. We need to become centered within ourselves, drawing strength from a spiritual or other internal source.

When do we need support?

Most of us were taught to be independent, strong, and self-sufficient. It's easy to get confused when our feelings seem to be less than what we think others expect of us—or that we expect of ourselves. Accepting and coping with angry, sad, disappointed, or fearful feelings can be difficult. It can even be difficult to ask for help or to admit that we need it.

To learn when you need support, first admit and identify your needs and wants. Internal and external support is especially important in times of high emotional or physical stress.

Check your needs throughout the day and ask yourself: "What do I need right now?" You won't always get the support you need—from yourself or others—but you're more likely to if you're aware of your needs. If you don't pay attention to your needs, it's more likely that you'll *displace* your emotions.

What does *displacing* mean?

It's human nature for unsatisfied needs and emotions to express themselves in surprising ways, especially during times of high stress. The person who kicks the dog after a bad day at the office isn't really unhappy with the dog—that person has just displaced unfilled needs and unsolved office problems onto the dog.

Living in families—particularly families with children who have special needs—takes a lot of emotional, physical, intellectual, and spiritual energy. Your supply of energy has its limits; getting support can help you replenish your storehouse. When you don't take care of your needs and replenish yourself, you may displace your feelings onto other situations or people. That's more likely to create new problems than to solve old ones. Plus, unsolved problems can pile up and damage your sense of self-worth.

What does self-worth have to do with support?

Self-worth—how we feel about ourselves and the belief we have in ourselves—has a lot to do with what happens both **inside** and **between** people. With high self-worth, we believe that we are important, that we matter, and that we can do what life asks of us. We trust our own abilities and are more able to ask ourselves and others for help.

Self-worth is directly related to the quality of our relationships with others and the support we get from the people who are important to us. You have to identify what you need before anyone else can give it to you. Are you overwhelmed physically? Are you just too tired? Do you need someone to listen? Do you need to be held?

How can I get the support I need?

After identifying your needs, look around. Who's out there to give you support? Look inside yourself, too—you may have internal resources that you've overlooked.

Avoid blaming people when you reach out for support. Blaming people is seldom a way to get what you need and may even push others away.

Sentences that start with *you* often sound like demands or statements of blame. A "you message" sounds like an accusation, will usually fail to get your needs met, and may even create conflict.

Instead of saying, **"YOU never** help me transport Molly to her medical appointments, and she's your daughter, too," take responsibility for your own needs by using "I messages" and smaller words.

"I messages" are clear statements of your feelings, needs, and wants. They start from a position of self-respect and show respect for the other person. "I messages" aren't demanding or blaming, but simply say what *you* need and want: "**I need** some help with taking Molly to medical appointments."

Never and *always* are big words. They can cut you off from the person you are trying to connect with—the person whose support you are seeking—because they can put the person on the defensive. Instead, try *sometimes* or *it seems*: "**Sometimes I** need some help taking Molly to medical appointments."

What does getting have to do with giving?

Living in a family group is a matter of creating a balance between giving and taking. It's critical that you don't always *take* support—you need to *give* it, too. The needs of everybody in the family must be balanced. Find a way to determine who has what needs and which needs must be filled first.

Sometimes there's not enough "giving" within the family and you need to look elsewhere to have your needs met and your self-esteem restored and replenished. Make sure you support the family—not destroy it—when you seek outside support. Seeking professional help is one constructive way to go outside the family for support.

What are social networks?

It's *your* job to create a social network that supports you when you need help and lets you help other people when they need it. Social networks are groups of relatives or friends who care about each other and understand the values and life issues of the people in the network. It's especially important to have a social network to rely on when your family and other people who are emotionally close to you are not available.

Sometimes a skilled, objective helper outside your circle of day-to-day friends can help you sort out your emotional issues and pain. Social workers, psychologists, and other helping professionals can also help you expand your social network and give the support you need during difficult times.

Taking Care of Yourself

by Kathleen Walden DeVerna

Being a parent is hard work. The hours are long, there is no pay, and the job is difficult—physically and emotionally. It is also one of the most rewarding things a person can do. Few parents would trade the job for any other.

Since you'll have this job for a long time, it makes sense to develop some good work habits. Caring for and challenging children are important habits. Caring for and challenging *yourself* are just as important. You will be better able to respond to the needs of others if you take care of yourself along the way.

How do I develop good habits?

You probably already have lots of good habits. Make a list of the ways you take care of yourself and your family—you'll see why your days always seem so busy. Keep this list and look at it from time to time to remind yourself of all the wonderful things you already do.

Now make a second list. This time, write down what you feel you need to make your life easier or better. Put the most important items at the top of the list and the least important at the bottom. Choose two or three items that are very important to you.

Let these items be your goals. If a goal seems too large or too complicated, break it into smaller steps. Maybe you can't take a two-week dream vacation right now, but you *can* get away for a long weekend. Or how about arranging a break for yourself once or twice a week? Even setting up a special savings account for when you *can* take that trip can be encouraging.

Decide what fits for you and your family. Setting goals for yourself and working on realistic steps can help you make the progress you want. Review your goals and progress regularly, to see how much you've achieved and to determine what to work on next. If you aren't making the progress you expect, reexamine the goal, adjust the steps, or maybe take a break for awhile. There's always another day or another way.

I never have enough time!

Most people feel there's not enough time to get everything done, and parents are no exception. Managing your time better may help. As a first step, to organize each day every morning:

Make a list of what you need to do that day.

Cross out each activity as you complete it.

At the end of the day, notice how much you've done and move whatever's left to the next day.

Meeting with doctors, therapists, teachers, and others can keep you pretty busy—even parents without all these extra appointments are busy. A weekly, monthly, or yearly calendar will help you keep track of your time. Fill in appointments as you make them, and review the schedule from time to time.

A written schedule helps you make sure you are doing what *you* want to be doing, and makes it easier to say "No!" to unimportant appointments. Share your calendar with people who don't understand why you can't make an appointment. Most professionals understand when parents are trying to organize their time—they work hard to manage their time wisely, too.

Get the help you need, the way you need it

It might help to talk things over with your family, friends, co-workers, or other supportive people. They may want to help but don't know what to do. They may be waiting for you to ask. Your spouse may not volunteer to take over one of "your" chores but might be quite willing to give it a try if asked. A co-worker or neighbor might enjoy cooking a meal for your family during a particularly stressful time. Aunts, uncles, grandparents, and even siblings often want to be useful—they just need to know what to do.

This doesn't mean that anyone wants to be obligated to take over all of your responsibilities. Resentment can build when people feel pressured. But if you ask for and appreciate their efforts, they'll be more likely to feel good about what they're doing. And they'll probably want to continue to do more.

Here are some other ways to get support:

- Some churches have parenting or support groups. They may provide child care during their group meetings.
- Many communities have organized parent enrichment classes.
- Often parents organize their own cooperative educational, support, or child play groups to meet their own needs. The public library has ideas for starting these groups. Some of the best support groups have been started *for* parents *by* parents.
- Some parents hire help to take care of routine chores so they have more time to spend with their family.
- Therapists, teachers, and physicians may be able to show you how to handle your child's special needs in easier ways. If you have a question, ask.
- Social workers know of community programs that help support families in need.
- Stress, time management, or assertiveness training may be helpful and available in your community.

What else can I do?

Set up a daily routine, leaving plenty of time to get things done in a relaxed manner. Many children don't like to be rushed. They want and need to participate in each activity to the best of their abilities. When they're hurried, they may become disorganized, agitated, or easily frustrated. It may seem as though it takes longer to get a child up and dressed in the morning without rushing, but things will be easier in the long run.

To make your daily routine run smoother:

- Start the morning earlier.
- Arrange the room so the important things are available and the rest are put away.
- Child-proof the room to cut down on obstacles, hazards, and distractions.

Try lowering your standards on unimportant things. It really isn't that important if the house is a little dusty. The lawn will survive even if it isn't mowed every weekend. But there *will* be problems if your needs and the needs of your family aren't met. Decide what's really important to you and stick with it. It doesn't matter if your home is perfect—what *does* matter is how each and every member of your family feels. These feelings last a lot longer than a dusted coffee table or a waxed car.

What about those "blue" days?

It's normal for feelings to greatly affect how much and how well things go. Parents have a variety of feelings even under the best circumstances. When there is a problem, the feelings may be exaggerated.

Feelings of denial, fear, anxiety, guilt, bargaining, anger, and depression are expected and even healthy. These feelings let people work through their grief over the loss of the child they dreamed about and help them build new dreams for themselves and for the child they do have.

Find someone to talk to—someone who understands how you think and accepts your feelings. Being able to talk about what is going on can be the best therapy. If you need more help, please ask—professional help is available in most communities. No one can "fix" things for you, but a good listener is a valuable friend and a real help during difficult times.

Summary

Taking care of yourself isn't easy, but you have a long, complex job ahead of you. If you take good care of yourself as you go along, it may make the work a little easier and a great deal more pleasant.

Humor for the Health of It

by Karla Garis, B.S.

Parenting can be a very serious and stressful business. But there's no reason for it to be solemn, too—laughter and a sense of humor can make some of life's roughest roads smoother.

Laughter is good exercise

Laughter causes several positive physical changes—you're already familiar with most of them. Think of the last time you laughed so hard you were in tears. Did you know that, along with the good time you were having, you were getting a good workout? Laughter has been called "internal jogging," and a great belly laugh can provide up to forty-five minutes of relaxation.

Here's how it works:

1. Laughter is a series of spasms of the diaphragm—the muscle between the chest and abdomen that is most involved in breathing.
2. The spasms cause the lungs to expand and take in more oxygen. They also help to clean out the lungs. Remember what happened right after your belly laugh? You probably coughed and coughed. That deep, active breathing is great for the respiratory system.
3. At the same time, the heart is pumping more blood—and oxygen—to all parts of the body. Circulation and muscle tone improve. Blood pressure is lowered, too.
4. All this activity increases the rate of digestion. That's reason enough for several laughs a day!

Laughter is a natural painkiller

When you laugh, your brain releases pain-reducing chemicals into the bloodstream and helps the healing process. So humor is not just a laughing matter—it's serious business.

Humor as a survival tool

A sense of humor is more than just laughter—the ability to see the humor in a situation is as important as the laughter itself. A good sense of humor will help you take a comic view of life's most trying moments. Can you choose laughter over irritation when:

- You're caught in a traffic jam?
- The toothpaste rolls off your brush just before it reaches your mouth?
- The airline loses your luggage?

Laugh first at yourself

A sense of humor lets you be productive and roll with the punches at the same time. To build up your sense of humor, start with how you see yourself—once you learn to take yourself less seriously, chances are you'll become more tolerant of others. Can you see the humor in your own flaws? Can you laugh at your own mistakes? Being able to laugh at yourself with love and acceptance builds the foundation for a healthy outlook toward yourself and the world around you.

Bringing more laughter into your life

Things don't have to be funny to make us laugh. Playing with children, going to lunch with good friends, or watching a beautiful sunset can put a smile on anyone's face. Finding joy in life can make us laugh.

Here are some ways to bring more laughter and joy into your life:

- Use humorous quotes to help keep your perspective—and your sanity. Try: "When the going gets rough, the smart get laughing," or, "When life hands me lemons, I'll make lemonade."
- Use a signal (such as putting your thumb to your chin and wiggling your fingers) to break the tension when you feel a family conflict brewing.
- Pick friends who aren't afraid to laugh—even at you.
- Add humor to your home. Use the refrigerator as a "humor bulletin board" to collect your favorite jokes, cartoons, or silly family photos.

- Keep your own humor-in-parenting notebook. Write down the funny family predicaments you encounter. Don't forget to include your own parenting bloopers.
- Start a humor support group. Get other parents together to have a good time and share their funny experiences.
- Create your own family humor rituals. You might read the comics in the Sunday paper together, have a joke-sharing session, add humor to birthdays and other family celebrations by dressing up like a clown, or tell funny family stories at holiday get-togethers.
- Adopt an attitude of playfulness. Do something different or unusual just because it's fun.
- Make others laugh. By creating happiness for others, you'll experience a special joy of accomplishment that only a lively, generous sense of humor can bring.
- Put together your own personal or family humor first aid kit. Collect funny games, toys, hats, puppets, buttons, books, T-shirts, and audio tapes. Use them as safety valves when confronting a crisis.
- Adopt a homeless pet. The laughs a kitten or puppy can bring can be the best medicine. Holding and cuddling a pet can even lower your blood pressure.
- Make a list of all the things that bring you joy in your life. Then prepare yourself to see nothing but that list!
- Video stores are filled with terrific comedies. Pick one out for a treat one evening. Make some popcorn and invite a new friend over for a fun-filled experience.
- Be willing to celebrate how funny you really are. Laugh at yourself so others can laugh at themselves with ease.
- Take a humor awareness class at your local college or university.
- Make a "crisis meter" to hang in the kitchen. The chart can have a movable arrow with readings such as "All Clear," "Watch Your Step," "Danger," and "Blow-up." Use it to break the tension.
- Put a joke book in the bathroom. Read from it first thing in the morning.
- When tension gets too thick, start singing. That can clear the air—and maybe even the room.
- Say something positive to the first sour-faced person you see each day.
- When your child is annoyed or pouting about something, say: "Don't you dare smile!" That should bring about laughter for both of you.
- When things get really hectic, try to step back and view your life as a situation comedy.
- On April Fool's Day, have a "backwards dinner" with your family or friends. Start with dessert and go from there.
- When your day is going from bad to worse, ask yourself: "Am I having fun yet?"
- Whenever you make a mistake, simply say: "I'm smarter now."
- Add "having a good time" to your definition of success.

Every life is richer with laughter in it. One of the greatest gifts you can give your child—and yourself—is the gift of humor.

Going Out!

by Chris Medvescek, B.A.

Traveling with a child with a disability isn't always easy. Even short trips around town can be hard. Your child may need to be carried, or is in a wheelchair, or has a chronic medical problem.

It's also hard emotionally to go out. Sometimes your child's behavior or looks don't fit "the norm." Sometimes children stare and adults say well-meaning but insensitive things. Sometimes you get sick of answering questions or making excuses. And sometimes it hurts to see other children doing things your child can't.

Some parents cope by not going out with their child at all. This is especially true in the early years of a child's disability. Emotions are close to the surface, and any added stress—even a quick trip to the store—can seem like too much.

You may feel isolated—like you're all alone. It can seem as though nobody understands what you're going through and that it's easier to stay home and avoid the whole thing. But isolation just makes things worse. It can lead to depression and to feeling trapped. You can lose your sense of perspective, and your child's disability can become larger than life.

You need the company of other people. You need to make your child's disability a part of everyday life. And most importantly, you and your child need to have fun.

Your child's only contact with the world is through you. If you don't go out, the child doesn't go out. Teaching your child to cope with the real world might be your most valuable gift.

Teaching social norms

The best time to start is as soon as you can. Your child will adopt your attitude; if you act ashamed and shy about the disability, chances are your child will, too. If you hide, you increase your child's feelings of being different.

But if you have the courage to be open and friendly, so will your child. By learning how to deal with going out, you're teaching your child how to do it, too. All it takes is time, practice, and the courage to take a risk.

Other people's reactions

Do you remember how you reacted to disabled people before your child came into your life? You probably didn't know quite what to do. Ignorance often comes across as insensitivity. Here are ways other parents have made things easier.

Tell yourself: "People don't mean to be cruel when they stare, ask blunt questions, or say something that hurts. They don't know what they're doing, and they're not really part of your life anyway. They don't matter." Say that to yourself—firmly—and then forget them.

Have answers to common questions and a short description of your child's problem ready. Doctors and therapists can help you with this. Use simple language and don't go into details. Add a positive statement ("She's very happy." "He loves playing with his brothers.") to help people see your child as a child.

Display your child's name as a way to help people see beyond the disability. Embroider your baby's name on a bib; your older child can have a T-shirt with a name on it. Put a nameplate on the wheelchair. Children with names are much easier to approach.

Encourage your child to talk to or smile at other people in public—it's a very normal "kid" thing to do. If able, the child can answer any questions about the disability. It's good practice for the child and helps others see the child as an able person.

The way you treat your child affects other people. Making public expressions of love and respect encourage others to do the same.

Local outings

Know and respect your child's limits. Avoid trips when the child is sleepy or hungry—why make things more difficult?

Especially in the beginning, bring someone—a friend, relative, or baby-sitter—along to help out.

Music is a great distractor, particularly when a child must be quiet for long periods. Bring along a child's tape recorder or an inexpensive cassette player with headphones, and a stock of children's tapes.

Call ahead to see if a location or event is appropriate for your child. Is it wheelchair accessible? Does it have things for your child to do? Some places, such as zoos or museums, have special programs for people with disabilities.

Find programs your child might enjoy, such as swimming or horseback-riding classes for disabled children. For ideas, contact a hospital social worker, service agency for disabled children, the Red Cross, the local YMCA or YWCA, or church group.

Look into groups designed around your child's handicap, such as the Spina Bifida Association or Association of Retarded Citizens. They will have tips suited to your child's needs. They can also give much-needed support.

Long trips

This section boils down to two words: Plan Ahead.

A few days before the trip, write down everything you use in a day: medicines, equipment, toys, clothing, special food, space to change diapers or perform procedures, quiet rooms for naps, lots of paper towels—everything. Pack and plan accordingly.

In case you need medical care, ask your doctor for a letter explaining your child's disability. Ask if your doctor is willing to be consulted by phone—the more complicated your child's case, the better it is to deal with your own doctor. For an extended visit, ask your doctor to recommend a doctor in the area. Take important medical information and prescriptions with you. If you're not sure what to bring, ask your doctor.

All trips have boring spells. Pack a bag of surprises, and don't forget the music. Try not to do too much in one day.

Don't expect your child to enjoy sitting still and looking all day. Even an amusement park can be boring if you can't join in. Look for fun things which will stimulate your child's senses—a petting zoo, a grassy meadow to roll in, a dip in the ocean, a boat ride, or a big brass band.

Be an ambassador

You are an "ambassador for disabled people" when you take your child out. You teach people when you answer questions, and you show that disabilities can be overcome. By loving your child in public, you show how normal your child really is. By sharing your child with the world, you are enriching others.

There may be times when you don't feel like being an ambassador. If you feel like telling the world to just go enrich itself, that's okay—nobody has to be on the job around the clock.

The important thing is that you balance your private time and your public time. Going out is a healthy, fun part of life. Don't deny it to yourself, or to your child.

For more information

The Society for the Advancement of Travel for the Handicapped
26 Court St.
Brooklyn, NY 11242
(718) 858-5483.
For written information, send $1 and a self-addressed envelope.

The National Easter Seal Society
70 E. Lake St.
Chicago, IL 60601
(312) 726-6200.
Provides references for information on disabled access and for finding out-of-town therapy services.

The Travel Information Service
Moss Rehabilitation Hospital
12th St. and Tabor Road
Philadelphia, PA 19141
(215) 329-5715.
Provides information about hotels and transportation for disabled people.

Dealing with Your Child's Difference

by Elaine Prosnitz, M.S.

Your child has special needs. You have to cope with the daily needs of your child as well as face your own feelings and fears. You may ask yourself:

- What do I tell my family? My friends?
- How do I respond to those stares in the store?
- What do I say to strangers who ask about my child?
- How can I get on with my life?

Here are three important concepts that may help organize your thinking.

Disability. Every person is unique, but everybody needs respect, comfort, love, and equal opportunity. A disability adds to the challenge of daily living and learning and may call for extra services or different ways of learning and adapting. A disability should *never* deny an individual's value as a person.

Normalization. We tend to expect less from—and often isolate—the person who has a disability. But *all* children need the chance to grow and develop; keeping a child out of the mainstream of childhood activities limits the child's opportunities for growth.

Normalization means:

- Having expectations for your child
- Giving your child the chance to play with and be with others in all kinds of places
- Having positive ways—not labels—to talk about your child
- Seeing all the good things your child does, instead of focusing on the disability
- Realizing that your child is happy if *you* are happy
- Giving your child the chance for a good future
- Helping your child develop to the child's greatest potential.

Self-esteem. Your love, energy, time, and hard work do the most good when you first accept yourself and meet your own needs. You must truly *like yourself* before you can nurture others. Self-esteem means:

- Knowing that you are a good and loveable person—someone who is important to others
- Finding ways to be happy
- Knowing that you are a friend to yourself and to others
- Knowing that you are a unique and special person.

What's the next step?

Meet your own needs. Accept yourself. Learning is a life-long process—you have skills you don't even know about yet. Positive parenting skills and the ability to cope with stress will develop along with your own feelings of self-worth.

Some habits and ways of thinking do you no good. Try to stop:

- Living in the past
- Blaming yourself, your spouse, your parents, or your life
- Comparing
- Feeling sorry for yourself

Instead, try to start:

- Living in the present
- Living each day as it comes
- Developing a positive attitude
- Creating a positive environment for your child and your family
- Honestly exploring your feelings
- Expressing your anger, frustration, and tears
- Gathering information to help deal with unknowns

- Talking with others—join a parents' group
- Using "respite" sitters who are specially trained to care for your child
- Learning relaxation techniques to reduce tension and stress
- Taking control.

What are some strategies I could use?

A person in the grocery store stares at your child. The person asks what's wrong. Let your child talk through you:

> "My name is Billy. I have a disability (or Down syndrome, cerebral palsy, etc.). I'm a happy, loved baby. I'm learning to sit up by myself. I'm proud of what I can do. So are my parents!"

A relative says something about your child's size. ("When is Carmen ever going to grow? She's still so small!") Let your child talk through you:

> "I'm playing with the rattle you gave me. I'll grow at my own speed. The important thing is that I'm healthy now. And, I'm happy!"

There are times when you don't want to discuss your child. Feel free to say:

> "I don't wish to talk about it now." Or: "I appreciate your concern. Let's talk another time."

Rude behavior is annoying and makes you angry. Let people know, in a nice way, that their behavior hurts you. Be direct. Use a calm, quiet voice.

> "Your staring is unkind. It hurts my child's feelings. It hurts my feelings."
>
> "I consider your staring (or questions, not calling, comments) thoughtless. Would you like to *meet* my child?"
>
> "I need your support now. My child has special needs." Then say what the person could do to help.
>
> "I'm not happy with the situation, but I'm coping. Your behavior only makes my situation harder."

Most people don't mean to be rude or thoughtless but are often unsure of what to do or how to behave. It's easy to form opinions about people who are different before knowing the facts. As a parent of a child with a disability, you can remind others that your child is not so different, and that being different is okay.

Point out that all people need:

- Love
- Respect
- The opportunity to learn, play, choose, work
- Friendship
- Freedom
- Power.

Summary

You are the parent of a child with a disability. You and your child have great challenges to meet. It's important that *you* feel good about yourself—you'll be more able to care for and support your child once you learn to cope. Develop goals for yourself. Live day to day. Get as much information as possible. Don't cope alone—find help in the community, and become involved in your child's programs. Be honest—with other people and with yourself.

For more information

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222

Being Partners with Your Child's Service Providers

by Chris Medvescek, B.A.

What is a partnership?

You probably know more about your child's disability than anyone else in the world. You know your child as a person, not a medical problem. And you see all the service providers—doctors, therapists, and teachers—who work with your child.

You're much more than a taxi driver who shuttles from one appointment to the next—you're a "central control" for information about your child, and your input is a vital part of your child's care.

A partnership means working on the same team for the same goal. But sometimes it feels like parents and professionals are on different teams. When this happens, parents can feel ignored, put down, or criticized. No one seems to be listening to them.

Developing a good partnership with your child's service providers means listening and learning from each other. It doesn't mean you will always agree with each other—that doesn't happen even in marriages! It *does* mean that you will be honest with each other, respect each other, and try to work through problems together for the benefit of your child.

How can you build a good partnership?

Teamwork doesn't just happen. It takes effort on both sides. The most important element is good communication. Here are some ways to communicate better:

Tell the service providers you want a partnership. They need to know you want to be actively involved.

If you don't understand, say so. There are no dumb questions. Seeking information is a sign of intelligence. You need to understand what's going on in order to make good decisions and to care properly for your child.

Make a list of questions or things you want to discuss. This helps make sure you cover all the important points. Being prepared also shows that you respect the professional's time. Some professionals tend to rush in and out of a visit. Say that you have a list of questions and show the list—most professionals will be willing to stay long enough to deal with the entire list. If not, set up another time to do so, perhaps on the telephone.

Repeat what you hear in your own words. Say: "Let me see if I've got this straight," and then explain what you understand. Don't be embarrassed if you get it wrong—this is complicated stuff! By putting it into your own words, you can be sure you really understand it. It also helps the professional to explain things a little more clearly.

Follow through on the service provider's recommendations. The partnership won't work if you don't hold up your end of the bargain. Write down complicated instructions. If the recommendations don't work, be sure to tell the professional so that adjustments can be made.

Go with what you know!

Trust your instincts about your child. You see your child every day—the professionals don't. If a doctor tells you something that doesn't agree with your instincts, keep searching for an answer that makes sense to you.

Here are some things you can do on your own as a full partner in your child's care:

Tell the professionals what you see at home. Several days before an appointment, start a list of your child's symptoms. Each time a problem occurs, write down the time, how long the problem lasts, and other information you think is important. This can help in making a diagnosis.

Get and keep copies of all of your child's medical records. As a parent, you're entitled to them. Get copies of the actual x-rays and scans (not just the reports) and muscle biopsy slides. If you are going to several doctors or hospitals, keep your own file of medical records. This cuts down on lost records and speeds up the process when you start with a new professional. Plus, some hospitals destroy x-rays, scans, and biopsy slides after several years.

Keep a notebook or medical "resume" for your child. List dates and results of hospital stays and medical procedures. This may seem unnecessary at first, but your child's case may become more complicated as time goes on. You'll be glad everything is written down, instead of having to rely on your memory or wade through a stack of medical records.

What if the partnership isn't working?

Many things can interfere with good communication. You can be stressed, angry, or emotional because of your child's problem. Professionals can be overworked and rushed. Because they deal with heartbreaking cases every day, some professionals may protect themselves by seeming distant and cold.

Here are a few things to try if you're having trouble working with a service provider:

Be polite. Talk to the professionals the way you want them to talk to you. Being assertive is not the same as being rude. Common courtesy goes a long way.

If you're feeling too emotional, overstressed, or angry, don't discuss your child's case. Tell the professional that you need to talk, but that you just can't handle it right now. Ask to set up another meeting, perhaps by phone. This will give you time to gather your composure and your thoughts. Write down what you want to say, to help you focus.

Remember: It's not the professional's job to give you support. It's great when it happens, but it's not part of the job. For support, try parents' support groups and counselors.

Show the professionals some sympathy. Everybody can have a bad day. It's easier for them to relate to you as a person with feelings if you treat them that way, too.

Confront problems directly. Say: "I need to talk to you. We seem to be having a problem."

The "I Message"

There is a formula you can use to get your message across without putting the other person on the defensive. It's called an "I Message" and it goes like this:

> I feel (your feeling)
>
> when you (the problem)
>
> because (your need or opinion).

For example:

> "I feel upset when you leave without answering my questions because I need to know what's wrong with Johnny."

Don't turn this into a putdown. Don't say: "I feel upset when you leave without answering my questions because you don't care about keeping me informed." One way to avoid this is to never start the last part of the formula with the word "you."

Use neutral words. For example, try the words "rush out" instead of "leave." Do you see how "rush out" is more judgmental? The point is not to make the other person defensive, but to get the person to listen to your problem. Test the sentence on yourself, and see how you would react.

This formula really helps! It keeps the focus on the problem and not on accusations. Practice saying it before your meeting with the service provider.

What if I disagree with the professional?

First, make sure you understand each other. Repeat the professional's opinion in your own words, and ask if you've got it right. Then ask to hear *your* opinion: "I want to make sure I'm making myself clear. Tell me what you think I'm saying." Politely correct any errors. Sometimes disagreements are just misunderstandings in disguise.

Not every partnership works. If you've tried to work with a professional but feel like you're not getting anywhere—or if you're just not comfortable with the person—keep looking. You owe it to your child and yourself to have the best possible working relationship with your child's team of professionals.

Parents as Advocates for Children

by Elyda S. Elwinger, Ed.D., O.T.R., CCC-Sp.

As the parent of a child with a disability, you're probably surrounded by advisors and authority figures. Well-meaning relatives, neighbors, and friends tell you whom to see and what to do, while doctors, therapists, and teachers all have different suggestions. How do you know what's best for your child?

When it comes to your own child, *you* are the expert. You can recognize your child's anxiety, fear, hunger, or sleepiness long before other people do. This personal knowledge can help you become your child's primary advocate.

What is an advocate?

An advocate is someone who protects someone else's rights and interests. Children—especially those with disabilities—are unable to obtain rights for themselves, so adults must "stand in" for them.

How can I become a good advocate?

You are your child's earliest and most important teacher. Learn to teach your child to overcome disabilities. Concerned professionals can help; your child's early training will work best when you work closely with specialists.

Be an active member of your child's team of service providers. Learn about normal development and your child's specific problems. Learn about the roles of various team members. Professionals often disagree among themselves; it's your job to understand the issues and help the specialists develop the best program for your child. Then help make the program work.

What is my role as an advocate?

As your child's advocate, you need to:

- Stand up for your child's needs and rights
- Make important decisions about your child's care
- Decide which specialists to see and which programs to enter
- Learn what placement is best and whether educational plans are right for your child.

All parents are concerned about what their children will be able to do as they grow up. Ask yourself: What can my child work on *now* to achieve *later* goals? This planning is not easy; the Individual Family Service Plan (IFSP)—a special education planning tool for infants and preschoolers—can help you decide how much help you will need.

Your child has rights, too!

Your child has basic rights to food, clothing, home, love, and security. Another basic right is the right to become as capable as possible. And your child has the right to an independent, fulfilling life. Defend these rights when planning programs for your child.

What is the parent-professional balance?

Advocacy is not just for parents. Everyone who comes in contact with your child becomes an advocate. You are emotionally involved with your child; professionals are usually objective and can help you make major decisions wisely. Respect their opinions.

Can I be an advocate at my child's school?

Yes! Here are some ways you can help:

Assessment. Learn to observe behavior, collect data, try out new activities, and chart progress.

Placement. After your child is evaluated, help decide whether placement or service suggestions are appropriate.

Program planning and curriculum. Make sure your needs, your child's educational needs, and future demands are considered.

School-home curriculum. Your child will do best when you work with teachers. Work done at school is not truly learned until your child can do it at home, too—keep teachers informed about such "carry-over."

Evaluation. Ongoing evaluation helps determine if your child is making progress. You can help by noting whether behavior transfers from school to home.

Long-term planning. Teachers may be more objective, but you may have more insight into effective goals for your child.

How can I succeed as an advocate?

Here are some tips for working with other team members:

Prepare thoroughly for meetings that concern your child.

Share information. Don't assume that specialists know everything about your child. *You* know what pleases your child, what is scary, what makes the child angry, what helps the child work better with others, and what discipline works best.

Expect your child to change. New behaviors may be due to growth, not the school program. Work closely with teachers to make behavioral changes easier to live with.

Understand that teachers care for and teach other children, too. If the teacher seems rushed, don't assume the teacher doesn't care about your child.

Let the teacher know about your suggestions and ideas, and about changes in home schedules.

Help plan field trips, birthday parties, and other school events.

Admit when you don't know what to do. Ask about how to get more information. The more you know, the better prepared you are to plan and make decisions.

Respect your child and your child's rights.

Listen to specialists. Be open and friendly.

What are parent advocacy groups?

Advocacy groups usually work for local school changes and for state and federal laws. Parent advocacy groups have helped expand horizons for all children with disabilities—federal laws to help disabled children started as the dreams of parent groups. Parents working together have great power.

How can I help?

- Write letters and lobby at all levels.
- Speak before local and state groups.
- Provide educational exhibits at malls, meetings, and conventions.
- Join forces with other advocacy groups to seek basic rights and educational needs.
- Work with newspapers and radio and television stations to make the public more aware of problems and needs.
- Help develop and support new programs.
- Encourage other parents of children with disabilities to become active advocates.

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Organizing Your Child's Care

by Peggy Jorgensen, R.N., and Linda Tharp, R.N.

Have you ever felt the frustration of looking for a misplaced appointment or birth certificate? Have you ever forgotten an important phone number or the date when something significant happened? Because of your child's special needs, it's even more important to keep accurate records in a central place.

A well-organized notebook will help you to:

- Keep a complete history of your child's care
- Keep track of all the people, agencies, and companies involved with your child
- Provide basic information about your child so you and others can give consistent care
- Store articles, reports, and other important documents.

What materials do I need?

- A three-ring notebook
- Notebook dividers
- Pocket dividers for storing smaller, loose papers
- A blank calendar for the notebook. Many parents also carry a pocket calendar
- Homemade forms for recording the necessary information.

How do I set up a notebook?

Here are some divider headings that may work for you:

- Personal Information
- Important Phone Numbers and Addresses
- Care Plan and Schedule
- Therapies and Developmental Progress
- Calendar
- Health History and Records of Evaluations and Consultations
- Important Documents
- List of Specially Trained "Respite" Baby-Sitters
- Useful Articles or Information.

Here are sample pages of some of the forms you could make up. Your child is unique and special; adapt these forms so they work best for you.

Personal Information

Name ______________________

Address ______________________

____

Phone ______________________

Date of birth ______________________

City and hospital of birth ______________________

____

Social security number ______________________

Insurance company ______________________

Insurance policy number ______________________

Other important numbers ______________________

____

____

Family Information

Father:

Name ______________________

Home Phone ______________________

Work Phone ______________________

Mother:

Name ______________________

Home Phone ______________________

Work Phone ______________________

Siblings:

Name ______________________

Home Phone ______________________

Work Phone ______________________

Family Information

Grandparents:

Name ____________________

Home Phone ____________________

Work Phone ____________________

Other family or friends:

Name ____________________

Home Phone ____________________

Work Phone ____________________

Specially trained "respite" baby-sitters:

Name ____________________

Home Phone ____________________

Work Phone ____________________

Important Phone Numbers and Addresses

Physicians ____________________

____

____

____

Therapists ____________________

____

____

____

Teachers ____________________

____

Consultants ____________________

____

Important Phone Numbers and Addresses

Others ____________________

____

____

Medical Supply Company ____________________

____

Hospitals and Clinics ____________________

____

____

____

In case of emergency ____________________

____

____

Care Plan

Name ____________________

Date ____________________

Respiratory care (Oxygen use, aerosol treatments, tracheostomy care . . .) ____________________

____

____

____

Nutrition (Name of formula, any special instructions for mixing formula, date you started giving current formula, how much formula you give at each feeding, feeding schedule . . .)

____

____

____

228

Care Plan

Medication (Include name of medication with dose and times to be given, date prescribed, prescribing physician, possible side effects, reaction, and date discontinued. If the list is extensive, use a separate sheet to list medications.) ______________________

____

____

____

Other (This could include therapy treatments or routine appointments, dressing changes, learning activities. . .) ______________________

____

____

____

Health History

This could have several sections, including:

- A brief history of your child's birth and a summary of any hospitalizations
- A record of immunizations
- A list of any allergies or sensitivities
- A record of illnesses, including date, who was consulted, treatment given, date resolved
- A growth chart, including date of measurement, weight, height, and head circumference.

Daily Schedule

Account for all 24 hours of your child's day, including scheduled sleep times. If your child's care is very involved, you may want to use several colors, such as:

- Feedings: blue
- Medications: red
- Special treatments: green
- Therapies: yellow
- Rest times: purple.

Make this notebook available to physicians, therapists, and other caregivers, and bring it along whenever your child is hospitalized. A notebook can relieve stress on you—you won't need to remember everything, and you won't need to repeat information over and over. Because all the vital information is in one place, you'll save a lot of time, too. Most of all, a notebook can help you and other caregivers be more consistent and organized in caring for your child.

Planning Transitions for Your Child

by Elaine Prosnitz, M.S.

What is a transition?

A transition is a movement from one program to another, such as:

- From the intensive care unit to another nursery
- From the hospital to the home
- From an infant stimulation program to a play group
- From a home teaching program to a program at a center.

A transition happens whenever your child starts special therapy services, home nursing, or an infant stimulation program. A planned transition allows for a smooth movement from one program or service to another. The long-term goal of transitions is to move your child more and more into the educational mainstream of your community.

What's my role in the transition process?

You are the expert on your child. You know your child's development, strengths, and needs. You know how to set goals for your child. Here are some of the important roles you can take:

Advocate. You know your child the best. You are an important team member. Decisions about programs and services should not be made without you—use what you know about your child to make the best possible decisions.

Teacher. You are a teacher every time you talk to, play with, feed, bathe, and hold your child. You help your child practice skills at home and elsewhere. You can tell the program team what your child does at home and what works for you.

Partner. You can be the important bridge between programs and services. Identify your child's needs, and discuss your expectations with the team. Be sure the new program or service has up-to-date records. Get copies of *all* reports. Keep the reports in a notebook or file box. Take many pictures of your child. Keep a scrapbook.

You'll be writing an *Individualized Family Service Plan* (IFSP) with the team. Federal law (Public Law 99-457) requires an IFSP for preschool and infant programs for children with disabilities. Among other information, the plan must include:

- A written transition plan
- Your role in transition
- Your responsibilities for transition and those of the other team members.

How can my child and I have a successful transition?

You are part of the program team. Write a list of questions. You need to know:

***Who* is involved**—administrators, teachers, therapists, and other service people. Know everyone's names and what they do. Know who the contact person is. Know who is testing your child—you must give your written permission before anyone can test your child. Know who the case manager is and what the case manager's responsibilities are.

***What* programs are available.** Visit programs with your child. Meet teachers and look at the classroom. Ask about the services provided and how placements are made. If you have a home program, establish the days and times the service provider will visit. Ask about goals and objectives of the program.

***Where* the recommended program is located.** Get the name, address, and phone number of the contact person for the agency or service. Ask about transportation and carpools.

***When* the move is to happen.** Make an appointment with the administrator *before* any new program starts. Plan a time to share information about your child. Ask if a handbook is available. Plan for visits between programs. Make a video tape of your child.

***How* the transition is to be done.** Work with the team to write a step-by-step plan for the transition. The plan should have a time-line of the dates by which each step will be completed. Know who is responsible for what tasks.

Summary

Transition is the planned movement from one program to another. You play a very important role in your child's transition. Take an active part in making decisions—ask questions, visit programs, and get involved.

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All issues of *Exceptional Parent Magazine*

Understanding the IFSP

by Helen Herziger, M.S.W.

What is an IFSP?

The Individualized Family Services Plan, or IFSP, is a document that identifies your family's strengths and needs as they relate to your child's development. The IFSP also clearly states the goals—for your child and your family—toward which you and your *early intervention team* will be working.

Why complete an IFSP?

Public Law 94-457 increases the money supplied to states to provide educational programs for children with special needs from birth to age 3. The 1986 law recognizes that young children depend on their families for all their care and that if the children are to be helped, their families must be helped, too.

To make sure that happens, the law says that people who work with families of children with disabilities must make a plan—an IFSP—for the whole family. The IFSP is required for families of children from birth to age 3.

The IFSP lets you decide how an early intervention program will help your child and your family. It's your chance to tell those who work with your family how much help you want and in what form you want it. For example, you may want a home teacher to visit once a week and you need help finding a reliable baby-sitter, but you don't want to join a parent support group.

The plan also helps you look at your own family and focus on what is important to you and what you want to see happen for your children.

Who develops an IFSP?

Someone from an early intervention program will help you decide which family members, friends, teachers, therapists, physicians, and other professionals you want as members of your team. *You* decide which team members, if any, you want to help develop your IFSP. You also decide how much you want them to know about your family.

Who's in charge?

You are more than an equal partner on your team—as the parent, you have the final say in all team decisions. You let the other team members know what you want for your child and family. Their job is to find ways to help you reach those goals. They can help you make decisions by telling you what they think your choices are. They will share the benefits of their experience and training with you.

Suppose you want your child to be able to call your family members by their names. The speech therapist may tell you a few different ways to work on that goal. One way might be to have the therapist see your child once a week in an office. You could talk with the team about whether that would be possible; they could suggest ways to get your child to the office and could tell you what results to expect. You should consider the advice of all team members, but *you* have the final say as to whether you want the therapy for your child. If you don't want the therapy, the team could suggest other ways to work on your goal.

How others work with you to develop a plan is important. Team members should make you feel that your views are respected, that you are the expert on your child, that you are a capable, independent person, and that *you* make the decisions.

Does an IFSP promise more services or money?

No. The purpose of the IFSP is to identify your needs and plan how to meet those needs. The plan states what team members will do to achieve your goals; it does not guarantee that whatever you want will be automatically provided. Suppose you need a better- paying job to cover the costs of your child's care. The plan may list ways that you can look for a new job, or places in the community that can help with a job search. It doesn't guarantee that your income will go up.

232

What should an IFSP include?

There is no national IFSP form or standard way to develop an IFSP. Every state and agency must find their own way to plan with families. But each IFSP must have:

- A statement of the child's level of development
- A statement of the family's strengths and needs as they relate to the child's development
- A statement of major outcomes expected for the child and the family, as well as how and when it is hoped they will be achieved
- A statement of which early intervention services are to be provided
- A statement of when services are expected to begin and how long they will continue
- The name of the case manager—the person responsible for carrying out the IFSP and making arrangements with other agencies and people
- The steps to be taken to help the child start a preschool or kindergarten program.

The IFSP should be written in language that makes sense to you and is close to how you would say it. It should not use words you don't understand or that change the meaning of what you've said.

The IFSP should include only those parts of your family's life that you feel are important for your child's development. You don't need to talk about your personal life unless you think it relates to your child's development and you want to talk about it.

Help parents get involved with their child's learning and development . . .

PARENT ARTICLES (1987)
Edited by Margaret Schrader

Save time in parent consultations. This collection of more than 80 reproducible articles was written especially for parents by experts on special needs children and parent education. They provide valuable information on speech therapy and speech/language disorders, answer frequently asked questions, and suggest related activities to enhance children's speech and language skills. Each article features glossary, cross-references, and additional resources for further reading. **Catalog No. 7439-Y** **$39**

READ TO ME, TALK WITH ME
Language activities based on children's favorite literature (1987)
by Barbara M. Lockhart

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Articles About the At-Risk Neonate (1990)
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